PUBLIC HEARING
BY
JOINT LEGISLATIVE COMMITTEE
ON AGING

September 23, 1983

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BY

JOINT LEGISLATIVE STUDY COMMITTEE ON AGING

Columbia, September 23, 1983

Senator Hyman Rubin, Chairman

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The Annual Public Hearing of the Joint Legislative Study Committee on Aging was held in the Blatt House Office Building, Room 101/110, in Columbia, South Carolina, on Friday, September 23, 1983. The Hearing convened at 10:30 A.M.

Senator Hyman Rubin, Chairman of the Committee, called the Hearing to order and welcomed the speakers. In his opening remarks, Senator Rubin said that the great number of participants in this Hearing indicates the growing interest and concern for the well-being of the elderly so that we can keep working for a better way of life for them, as well as for their dignity and comfort. The Committee on Aging has been functioning for some 15 years, and this Annual Public Hearing provides a very valuable input. Some of the problems that are raised do not lend themselves to immediate solutions because of funding concerns, but they are educational to the Committee so that it can keep working on.

The Committee is regarded as not only one that proposes and carries through legislation but also as an advocacy group that endeavors to encourage the participation of private citizens and groups in assisting the elderly and, at the same time, is something of a clearinghouse of information.

The Committee functions the year round and is housed in the Senate Medical Affairs Committee suite and all the staff join together to provide services and answer questions which come up throughout the year. By pooling the staff the Committee is able to operate this Committee on a minimal expenditure of State funds. "The elderly have friends in the members and staff of this Committee. I think this is known and is always reassuring, no matter which group is involved or affected. We are grateful for the splendid cooperation we get from all the State agencies; they assist us in every way: the Attorney General's Office, DSS, DHEC, the Commission on Aging, and others. All of their information and resources and assistance are always available to us which enables us to cover a lot of ground," said Senator Rubin.

The members of the Committee were presented: Representative David Waldrop, Newberry County, Dr. Carlisle Holler, Representative Dill Blackwell, Greenville County, Mrs. Gloria Sholin, a Gubernatorial Appointee from Varnville, Dr. Julian Parrish, a Gubernatorial Appointee. Senator Peden McLeod joined the Committee later. Representative Harris was unable to attend the Hearing. Staff present were: Mrs. Keller Bumgardner, Director of Research and Administration, and Mrs. Rose Mary S. Smith, Administrative Assistant to the Senate Medical Affairs Committee.

At this point, Senator Rubin introduced Mrs. Rubin who attended the Hearing because of her great interest in the Committee's work.

The Agenda was taken up as follows:

Reverend M. L. Meadors, Chairman
SC Commission on Aging
Columbia, SC

Reverend Meadors expressed his appreciation to the Committee on its continued legislative progress for the elderly in South Carolina:

1. Condominium Conversion Act
2. Hospice Program
3. Home Health Services
4. Extension of Time to pay Property Taxes

He hopes that the Committee will continue its efforts to obtain the following:

1. Benefits for Volunteers
2. Revision of the Probate Code
3. Property Tax Relief
4. Alternatives to Institutionalization

He expressed his thanks especially for the introduction of House Bill H-2364, a Bill to Estabish a Program of Community Services for the Functionally Impaired Elderly. He called on Mr. Jim Dubs, Deputy Director, SC Commission on Aging, to give a more in-depth report on this Bill.

PRESENTATION TO
GENERAL ASSEMBLY'S STUDY COMMITTEE ON AGING
BY

REV. M. L. MEADORS, CHAIRMAN
SOUTH CAROLINA COMMISSION ON AGING
9/23/83

SENATOR RUBIN, DISTINGUISHED MEMBERS OF THE GENERAL ASSEMBLY'S STUDY COMMITTEE ON AGING: I AM JACK MEADORS, CHAIRMAN OF THE SOUTH CAROLINA COMMISSION ON AGING.

IT IS A PLEASURE TO COMMEND YOU ON YOUR CONTINUED LEGISLATIVE PROGRESS FOR OLDER SOUTH CAROLINIANS. PASSAGE OF THE CONDOMINIUM CONVERSION ACT, LEGISLATION REGARDING HOSPICE PROGRAMS AND HOME HEALTH SERVICES, AND EXTENSION OF THE TIME TO PAY PROPERTY TAXES ARE ADMIRABLE ACHIEVEMENTS.

YOUR EFFORTS TO OBTAIN BENEFITS FOR VOLUNTEERS, REVISION OF THE PROBATE CODE, PROPERTY TAX RELIEF, AND ALTERNATIVES TO INSTITUTIONALIZATION ARE GREATLY APPRECIATED. WE TRUST THEY WILL CONTINUE. I ESPECIALLY THANK YOU FOR THE INTRODUCTION OF H-2364 , A BILL TO ESTABLISH A PROGRAM OF COMMUNITY SERVICES FOR THE FUNCTIONALLY IMPAIRED ELDERLY. IT IS OF THE UTMOST IMPORTANCE THAT WE GIVE SPECIAL ATTENTION TO THIS BILL, AND I CALL ON JIM DUBS TO ELABORATE ON IT.

Mr. James D. Dubs, Deputy Director
SC Commission on Aging
Columbia, SC

He, too, urged continued support of House Bill, H-2364. He pointed out that while the Commission supports the request for in-home services in the Medicaid Budget, they do not see it as conflicting or duplicating the services called for in H-2364.

The Community Long Term Care population must be Medicaid eligible and at a level of impairment that requires skilled or intermediate nursing home care. However, there are many other impaired older persons who also are in desperate need of services.

A recent survey confirmed the Commission on Aging's expectation; i. e., the Community Long Term Care client population is sicker, and in many cases have already applied for nursing home admission. The Commission on Aging's clients were less impaired, and the majority are older women who live alone. They are not in immediate need of nursing home care, but cannot fully care for themselves. House Bill H-2364 provides for a fee scale for services. Those who can will pay, and the fees collected will be used for expansion of these services to others.

He wanted the Committee to know that the Commission feels both programs are needed and that they will complement rather than duplicate each other.

He touched on another problem dealing with the low rate of acceptance of Medicare assignment by physicians in South Carolina. On a recent visit to Pennsylvania he found out that 90-95 percent of the doctors accept Medicare assignments; whereas in South Carolina the percentage is between 5-10. When a doctor accepts assignment, he agrees to accept the approved Medicare rate for services rendered. If a patient has additional insurance to supplement Medicare, his or her bill will be paid in full. If a doctor does not accept Medicare assignment, then the patient is responsible for the difference between the Medicare rate and the amount the doctor bills for his service.

Unfortunately, he can not offer a solution to this problem as we can not force doctors to accept Medicare assignments. Other states are also looking at this issue. One suggestion is to require doctors to post a sign in their offices that statesthat they accept Medicare assignments.

Representative Waldrop asked Mr. Dubs to state his opinion again on Community Long Term Care.

Mr. Dubs replied that the Commission endorses the concept of Long Term Care being expanded. DSS will propose in their budget approximately the amount of $2.6 million in State funds, matched by Federal Medicaid funds, to move statewide with the kind of services the Demonstration Project has provided in the three counties in the Spartanburg area.

Senator Rubin added that the Bill on the Functionally Impaired is in the House Ways and Means Subcommittee, chaired by Representative Harris.

Chairman recognized Ms. Pat Antley, Richland County Auditor, Mr. Siau, Georgetown County Auditor, and Mr. David Denton, who recently started as Veterans Service Officer and Administrative Assistant to the Richland County Delegation. He called the Delegation Office another clearinghouse which can be of assistance in many instances.

PRESENTATION TO
GENERAL ASSEMBLY'S STUDY COMMITTEE ON AGING
BY

JAMES D. DUBS, DEPUTY DIRECTOR
SOUTH CAROLINA COMMISSION ON AGING
9/23/83

SENATOR RUBIN, DISTINGUISHED MEMBERS OF THE STUDY COMMITTEE ON AGING, I WOULD LIKE TO JOIN REVEREND MEADORS IN COMMENDING YOU ON YOUR GOOD EFFORTS ON BEHALF OF OLDER SOUTH CAROLINIANS.

I TOO WOULD URGE YOUR CONTINUED SUPPORT OF HOUSE BILL 2364, TO ESTABLISH AND FUND A PROGRAM OF COMMUNITY SERVICES FOR FUNCTIONALLY IMPAIRED OLDER PERSONS.

AS MEMBERS OF THE GENERAL ASSEMBLY LOOK TOWARD FUNDING OF THESE SERVICES, THEY WILL ALSO BE CONSIDERING A SIMILAR AMOUNT OF FUNDS REQUESTED IN THE MEDICAID BUDGET FOR IN-HOME AND COMMUNITY SERVICES FOR HEALTH IMPAIRED OLDER PERSONS. YOU HAVE SUPPORTED THE MEDICAID COMMUNITY LONG TERM CARE SYSTEM IN THE PAST, AND THE THREE-COUNTY DEMONSTRATION PROJECT IS BEGINNING TO SHOW POSITIVE BENEFITS, BOTH IN HUMAN AND DOLLAR TERMS, OF PROVIDING ALTERNATIVES TO NURSING HOME CARE.

THE COMMISSION SUPPORTS THE REQUEST FOR IN-HOME SERVICES IN THE MEDICAID BUDGET, AND WE DO NOT SEE IT AS CONFLICTING WITH NOR DUPLICATING THE SERVICES INTENDED IN THE COMMUNITY SERVICES LEGISLATION.

THE COMMUNITY LONG TERM CARE POPULATION MUST BE MEDICAID ELIGIBLE AND AT A LEVEL OF IMPAIRMENT FOR SKILLED OR INTERMEDIATE NURSING HOME CARE. THIS IS A POPULATION IN DESPERATE NEED. BUT THERE ARE MANY OTHER IMPAIRED OLDER PERSONS WHO ALSO DESPERATELY NEED HELP.

RECENTLY, A SURVEY WAS MADE THAT COMPARED A SAMPLE OF CLIENTS SERVED BY THE COMMUNITY LONG TERM CARE DEMONSTRATION PROJECT WITH EXPANDED MEDICAID SERVICES WITH CLIENTS SERVED IN OUR AGING NETWORK. THE COMMUNITY LONG TERM CARE CLIENT POPULATION WAS SICKER THAN OURS, WHICH WE EXPECTED. THESE WERE OLDER PERSONS WHO HAVE ALREADY APPLIED FOR NURSING HOME ADMISSION. OUR CLIENTS WERE LESS IMPAIRED; THE MAJORITY OF CLIENTS WHO ARE PROVIDED IN-HOME SERVICES SUCH AS HOME-DELIVERED MEALS AND HOMEMAKER SERVICE BY THE AGING NETWORK ARE OLDER WOMEN WHO LIVE ALONE. THEY ARE NOT IN IMMEDIATE NEED OF NURSING HOME CARE, BUT CANNOT FULLY CARE FOR THEMSELVES.

CLTC IS BASED ON MEDICAID ELIGIBILITY; THE PROPOSED COMMUNITY SERVICE LEGISLATION FOR THE ELDERLY DOES NOT. THE BILL PROVIDES FOR A FEE SCALE FOR SERVICES. THOSE WHO CAN WILL PAY FOR SERVICES, AND THE FEES COLLECTED WILL BE USED FOR EXPANSION OF THESE SERVICES TO OTHERS.

I HASTEN TO ADD THAT MY COMMENTS ARE NOT CRITICAL OF THE COMMUNITY LONG TERM CARE PROGRAM. THE COMMISSION SUPPORTS EXPANSION OF THE PROGRAM AND WE URGE YOUR CONTINUED SUPPORT OF THIS PROGRAM.

WE FEEL THAT BOTH PROGRAMS ARE NEEDED AND THAT THEY WILL COMPLEMENT RATHER THAN DUPLICATE EACH OTHER.

WHILE I AM HERE, I WOULD LIKE TO BRING ANOTHER PROBLEM TO YOUR ATTENTION. . . THE LOW RATE OF ACCEPTANCE OF MEDICARE ASSIGNMENT BY PHYSICIANS IN SOUTH CAROLINA.

DURING A RECENT TRIP TO VISIT MY FAMILY IN PENNSYLVANIA, I SPOKE WITH MY BROTHER, WHO WORKS FOR A HEALTH INSURANCE CARRIER THAT IS A MEDICARE INTERMEDIARY, ABOUT THIS PROBLEM. IT SEEMS THAT IN PENNSYLVANIA 90-95% OF THE DOCTORS ACCEPT MEDICARE ASSIGNMENTS; IN SOUTH CAROLINA ONLY 5 - 10% ACCEPT ASSIGNMENT.

WHEN A PHYSICIAN ACCEPTS ASSIGNMENT, HE AGREES TO ACCEPT THE APPROVED MEDICARE RATE FOR SERVICES RENDERED. IF A PATIENT HAS INSURANCE TO SUPPLEMENT MEDICARE, HIS OR HER BILL WILL BE PAID IN FULL.

IF THE DOCTOR DOES NOT ACCEPT ASSIGNMENT, THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE MEDICARE RATE AND THE AMOUNT THE DOCTOR BILLS FOR THE SERVICE.

I ASKED MY BROTHER IF HE COULD GIVE ME ANY REASON FOR THE DIFFERENT RATES OF ACCEPTANCE OF ASSIGNMENT. ALTHOUGH HE COULD NOT COMMENT ON SOUTH CAROLINA, HE DID SAY THAT IN MAJOR URBAN AREAS IN PENNSYLVANIA NEARLY 100% OF THE DOCTORS ACCEPT ASSIGNMENT, WHILE IN RURAL AREAS VERY FEW DO. IT SEEMS THAT IN RURAL AREAS PEOPLE TEND TO PAY DOCTOR BILLS BEFORE ANYTHING ELSE. IN URBAN AREAS DOCTORS ARE MORE WILLING TO ACCEPT ASSIGNMENT THAN TO RUN THE RISK OF NOT GETTING PAID AT ALL.

I SAID THAT I WANTED TO BRING THIS PROBLEM TO YOUR ATTENTION. UNFORTUNATELY, I DON'T HAVE A READY SOLUTION TO RECOMMEND. WE CERTAINLY CAN'T FORCE DOCTORS TO ACCEPT ASSIGNMENT, NOR CAN WE ENCOURAGE PATIENTS TO STOP PAYING THEIR BILLS.

OTHER STATES ARE ALSO LOOKING AT THIS PROBLEM. ONE SUGGESTION IS A REQUIREMENT THAT DOCTORS POST A SIGN IN THEIR OFFICES THAT STATES IF THEY ACCEPT ASSIGNMENT. THERE MAY BE BETTER WAYS TO APPROACH THIS, AND IT IS CERTAINLY A PROBLEM WORTHY OF FURTHER CONSIDERATION.

I WOULD LIKE TO THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOUR COMMITTEE, AND AGAIN COMMEND YOU FOR YOUR EFFORTS ON BEHALF OF OLDER SOUTH CAROLINIANS.

Mr. Tom Brown, Director
Community Long Term Care Program
Columbia, SC

Mentioning that he has submitted written testimony, Mr. Brown stated that he did not want to speak on the status of the Program in Spartanburg or the Statewide Management System, but report on the two most important matters, one being the summary of research findings from Spartanburg and the other which addresses the funding which is contained in the Medicaid Budget for FY 84/85.

They have been in the research phase in Spartanburg since July 1980 and are primarily concerned with community-based long term services on clients and are measuring mortality, change in functional status and overall change in health as well as cost of Medicaid and the use of nursing home care.

He summarized the findings of three different studies which they completed this past year.

1. Given the option for community-based long term care services, most Medicaid clients and their families will choose to remain at home as opposed to nursing home care.

2. Admissions and patients days in the nursing home have been reduced in the project experimental group that has had access to community-based care. Admissions to nursing homes were reduced by 16 percent and patient days of institutional care were 37 percent less than the comparison group.

3. They have been able to show that the system of community-based care is in fact less expensive to Medicaid--when considering all Medicaid expenditures--than the current system of care. This has been achieved primarily through the reduction in the use of nursing home care.

Based on these findings, the Long Term Care Policy Council which oversees the Project in Spartanburg is recommending in 1984/1985 an expansion of the same community-based services that are presently available under waivers in Spartanburg to the remainder of the State, so that the Statewide Community-Based Service System would be comparable, beginning next year if this is approved, to what they have been testing in Spartanburg. These services are: personal care, medical day care, expanded home delivered meals--both regular and therapeutic diet--

expanded therapies delivered to the home, and respite care.

This request is in the Medicaid Budget for a total of $9.9 million; $2.6 million in State dollars, the remainder in Federal Medicaid dollars. This amount will serve approximately 8,200 people, either partially during the year or for the full year, if they remain in the community for a full year. These are people who would be eligible under the current system for admission to a nursing home. To support his statements, Mr. Brown exhibited a chart, drawn up by Dr. Don Blackman of his research staff. It showed the cost for expanded services for those people who are currently eligible for Medicaid in the community; these are people who are eligible and are receiving SSI. The cost for these services would be $3.2 million and involves 2,600 persons in this group. Another group is also very important, they are those who are eligible for Medicaid services under the current system but only if they are institutionalized. They are proposing that the Medicaid Program be changed through waivers--statewide--to allow this group of people to receive Medicaid benefits at home in addition to the current system of benefits in the institution. There are estimated to be 5,600 people who will receive services next year. Of course, there will be more cost to add this group to the Medicaid Program. "We feel that, because of the savings we have been able to show in Spartanburg, this is an appropriate move to recommend to the General Assembly and the Governor and, of course, to this Committee."

They further recommend that the nursing home bed supply be not expanded until this system of services is in place. Analyses were done on what it would take to supply enough nursing home beds to accommodate this group of people. This would cost the State through the Medicaid Program considerably more dollars. The option Mr. Brown presented is about $8 million less than the nursing home bed option.

In conclusion, he urged support of H-2364, which in his opinion is not a duplication of this request, and in fact the two proposals taken together will give an excellent community-based service system for older people in the State.

Representative Waldrop asked for an explanation of "not to expand nursing home beds."

Mr. Brown explained that for a number of years there have been essentially no new nursing home beds available through the Certificate of Need process in the State. What they are recommending is to continue this moratorium for another

two to three years until their services are in place. The reason is, of course, that we can not have both but, in Mr. Brown's opinion, he does not think they are needed.

Representative Waldrop wanted to know if Mr. Brown thinks that it is a reasonable cause to move somebody out of a nursing home by means of a program that is enacted by what is proposed here or some other Medicaid/ Medicare purpose.

Mr. Brown assured him that the primary focus of this would be to assist people prior to entering a nursing home. The case Mr. Waldrop was referring to concerned someone who lost eligibility under the current rules for Medicaid in the nursing home.

Representative Waldrop replied that he was not getting on personalities, but wanted to express his concern about the Long Term Care Program when you have a handicapped person removed from a nursing home with no family to be cared for and nowhere else to go.

Mr. Brown explained that there are other options than family care, such as residential care facilities.

Representative Waldrop wondered if people there get sufficient medical attention.

Mr. Brown stated that people who do not meet an intermediate level of care can qualify and will be appropriately served in residential care facilities even if they have, for example, lost part or all of their extremities.

Dr. Parrish asked for a definition of residential care facility as opposed to nursing home care.

Mr. Brown said that the Medicaid medical necessity criteria for nursing home care relate either to the need and use of skilled services (nursing, physical therapy, etc.) or to the intermediate level which is appropriate for someone who is functionally impaired (bathing, dressing, eating, etc.) If a person does not meet the minimum functionally impaired level for nursing home admission, almost all of them would be entitled to services offered at residential care facilities. There are a small number of cases where the two services would not meet.

Representative Waldrop wanted to know if all of the $9.9 million is going toward the CLT.

Mr. Brown replied that all of it would be service dollars to be contracted out with hospitals, nursing homes, DSS, local aging units or new providers.

Senator Rubin expressed his appreciation to Mr. Brown for the concise report and called the Committee's attention to the fact that this Program was one that was originally sponsored by the Committee on Aging in 1977 and started as a pilot program in three counties. "We endeavor to follow it very closely."

Presentation to the Study Committee on Aging

September 23, 1983

Thomas E. Brown, Jr., Director

Community Long Term Care Program

Senator Rubin and members of the Study Committee on Aging, I would like to report on the progress of the Community Long Term Care Project in Spartanburg and the statewide long term care service management system. Before describing our progress since my last report to the Committee, I would like to express my appreciation and the appreciation of the Long Term Care Policy Council for the strong support which the Committee has given in the past to the project and the statewide system.

The Community Long Term Care Project was approved by the General Assembly in 1978 for the purpose of gathering information that the State could use in planning policies and programs for long term care. The project is administered by the Long Term Care Policy Council. The members of the Council are the Governor or his designee, the Commissioners of the Department of Social Services, Mental Health, Mental Retardation, and Health and Environmental Control and the Director of the Committee on Aging. Two specific items of interest were a long term care service management system which involves client assessment, service planning and case management and an array of new community-based services which might meet the rehabilitative and/or maintenance needs of long term care patients in non-institutional settings. The project received Section 1115 Medicaid waivers in July 1980 and Section 222 Medicare waivers in October 1981. These federal approvals authorize the use of federal matching funds from Medicare and Medicaid for the research and demonstration activities. The project began the experimental phase on July 17, 1980.

FY82-83 was the third year of the experimental phase of the Community Long Term Care Project (CLTC). During the year, 1316 individuals were referred for admission. As of June 30, 1983, there were 1186 residents of Spartanburg, Cherokee and Union Counties participating in the Community Long Term Care Project. Of this group, 651 were members of the experimental group and were eligible to receive the CLTC expanded community-based long term care services. The remaining 535 clients were members of the comparison group, which will provide baseline data to evaluate the cost and effectiveness of the CLTC experimental services. Of the experimental group clients, 66% were either skilled level of care or intermediate level of care on June 30 and, therefore, qualified for Medicaid reimbursed nursing home care. Out of this group, only 46% were institutionalized, while over 50% were receiving community-based services and less than 4% were hospitalized. When all experimental clients are considered, i.e. including those clients who need less than intermediate level of care, 65% receive community-based long term care services, 32% are institutionalized and 3% are hospitalized.

New community-based long term care services, which were used by over 300 experimental group clients, included personal care, medical day care, home-delivered meals for regular diet and special diet patients, respite care, medical social services and expanded home delivered therpaies. The most heavily used services were personal care, medical day care and home-delivered meals.

Other accomplishments during FY82-83 included initiation of the Medicare Section 222 waivers in April 1983, completion of significant research and evaluation reports regarding the cost and effectiveness of the CLTC Project, and implementation of the statewide CLTC Service Management System. Research and evaluation reports focused on client outcomes, change in functional status, mortality and mental status; Medicaid costs; and nursing home utilization. The reports compared 276 experimental clients and 339 control clients who had 18 months experience on the project. All of these clients were Medicaid eligible and skilled or intermediate level of care upon their entry into the Project. The major findings indicate that:

1) most Medicaid long term care clients and their families will choose community-based long term care services rather than institutional care when community-based services are available;

2) the utilization of community-based long term care services substituted for nursing home admission for some clients and delayed nursing home admissions for others. The impact of these two effects was to reduce nursing home admission by 16% and to reduce patient days of institutional care by an average of 37%; and

3) Medicaid costs for a system of community-based long term care services for Medicaid clients who are medically eligible for nursing home admission are lower per patient per day than cost of the current system.

In summary, it appears from these findings that Medicaid eligible long term care clients who have options regarding the location in which they receive care (i.e. community or nursing home) prefer community-based care and that utilization of community based care, as opposed to primarily nursing home care, is less costly for the State's Medicaid program and does not adversely affect client outcomes.

The Long Term Care Policy Council is very pleased with these findings, and is recommending that CLTC community-based services be made available on a statewide basis in FY84-85 through the Medicaid program. This recommendation is based on the very favorable findings mentioned above and is made after careful consideration of other alternatives to address the long term care service needs of the State's growing elderly population. The cost for these services in FY84-85 is estimated to be $9.9 million ($2.6 million in State funds). Over 8,200 Medicaid eligible, long term care clients are projected to receive home based care, 2,620 will be SSI eligible clients and an additional 5,600 clients will be covered for Medicaid noninstitutional and community based long term care services for the first time. Currently, these clients (up to 300% of SSI) are eligible for Medicaid only if they are institutionalized. The Council is also recommending that no additional nursing home beds be approved until the system of community-based services is in place and fully operational. The other option considered by the Council involved expansion of the current nursing home bed supply to accommodate the increased demand for long term care services. The cost to Medicaid for meeting this need through nursing home care is projected to be $18.8 million over current expenditure levels. This option would cost $8.9 million more than the community services plan proposed by the Long Term Care Policy Council. The establishment of statewide community-based services will complete the modification of the State's

long-term care system, which began in FY82-83 with the establishment of the CLTC Service Management System.

Following the approval of the statewide CLTC Service Management System as part of the FY82-83 State Appropriations Act, the Long Term Care Policy Council completed detailed planning and development activities for implementation of the program. The Health Care Financing Administration, U.S. Department of Health and Human Services, approved these plans in September, 1982. The program is designed to assist Medicaid eligible clients who need skilled or intermediate long term care services to receive care in their homes. Phase-in of the program was originally scheduled to begin in November, 1982. Due to a severe reduction in State funds in October, 1982, this schedule was delayed until March, 1983. As of August 1, 1983, all counties in the State have access to the CLTC Program. Approximately, 700 individuals are seeking Medicaid long term care services (i.e. institutional or community-based services) through the system each month. It is anticipated that more Medicaid clients will choose community-based care, and, therefore, reduce the need for expansion in the nursing home bed supply. Our program has enjoyed excellent cooperation from the existing community service providers and hospitals toward achieving this goal. By and large, home care services through Titles XVIII, XIX, XX and III have been used to assist long term care clients to remain in their own homes. These funds are not enough; however, and the additional funding mentioned above are necessary to establish a system of community care for Medicaid eligible clients who need skilled and intermediate care.

Additional services are sorely needed in our State by those individuals who would not qualify for Medicaid and yet who can not afford the cost of community based services. During this past year, I participated on a task force sponsored by the Commission on Aging for the purpose of developing legislation for community-based services for impaired elderly South Carolinians. Bill H2364 was introduced by Representative Harris, et al during the last Legislative Session. I would like to indicate my support for this legislation. Recently, I have been asked whether this proposal duplicates the services or targets on the same population for which the Long Term Care Policy Council is recommending community-based services under the Medicaid program. I am of the opinion that these two proposed service systems are not duplicative and in fact fit together very well in providing a comprehensive service system for the elderly and impaired. Therefore, I want to reiterate my support for Bill H2364.

Lastly, I would like to express again my appreciation for the support and assistance which our program has received from the Committee in the past, and I request your favorable review and support for the major new program of Medicaid community-based services which is being requested for FY84-85.

Mr. Bill Bradley, State Ombudsman
Governor's Office
Health and Human Services
Columbia, SC

The problem Mr. Bradley pointed out occurs in limited situations and covers a small number of people; however, he feels it is one that needs to be brought to the Committee's attention.

The first abuse laws written in the State dealt with children and it was not until 1974 that South Carolina passed its first adult abuse law. Even though this was just ten years ago, South Carolina today is recognized across the nation as a leader in this particular area. However, there is a flaw in the adult abuse law, which Mr. Bradley would like for the Committee to study and possibly remedy with an amendment.

Law enforcement officers have the power to remove children from abusive situations, but they can not remove adults, who in many cases are just as helpless as children, from abusive situations.

He asked that the Adult Abuse statutes be amended to give law enforcement officers the authority to remove helpless elderly persons from abusive situations.

Further, he suggested that they add to the amending legislation that law enforcement officers are allowed to remove a helpless individual from a "motor vehicle," and he cited an example to substantiate the need for this.

Legislation to this effect had been introduced by Senator Sanders; however, it remains in the Senate Judiciary Committee. Mr. Bradley suggested to introduce a new piece of legislation in House and Senate this year, and he urged the Committee to support this legislation.

Senator Rubin told him that they would certainly consider this.

Senator Rubin and other members of this Study Committee on Aging, today I would like to present an issue that I feel needs your consideration.

The first abuse laws to be passed were to protect children. Several years after the first child abuse laws were passed, South Carolina passed its first adult abuse law. This was in 1974 and South Carolina is recognized across the nation as a leader in this area. This law passed because of this Study Committee on Aging. Some of you were members of the Committee then.

Over the past few years incidents have occurred that have caused concern and have brought to light a weakness in the present adult abuse laws. There are situations that require adults to be removed from abusive situations immediately.

Law enforcement officers have the power to remove children from abusive situations, why should we not permit adults to be removed from similar type situations. Many of the adults are just as helpless as children and need to be taken into protective custody.

An example of what I am referring to, the Ombudsman Office and the Department of Social Services had been following a situation of a couple who were operating an unlicensed Residential Care Facility. The operators were changing locations almost monthly. The home was located, law enforcement and DSS went to the house; however, they were refused admittance because they did not have a court order. By the time a court order was issued, the elderly residents were transferred to another location. After a few weeks the new location was found. When the elderly were able to be removed by court order- two were found sleeping on the floor, there was no food in the refrigerator and only (3) cans of food in the pantry.

Because law enforcement did not have the authority to remove those elderly people, they were put through additional abuse.

Just recently we had a situation called to our attention when a woman was threatening to abandon her brother. She had taken him out of a nursing home, transported him over a hundred miles in her car and tried to force a Residential Care Facility to admit her brother.

I would like to request that you again come to the aid of the elderly and amend the Adult Abuse statutes to give law enforcement officers the authority to remove helpless elderly persons from abusive situations.

You can certainly count on our office to assist you in any way possible to help with this most needed legislation.

/ebh

Mr. David S. Pass, ACSW
Hospice Program Director
Greenville Hospital System
Greenville, SC

As the Director of a Hospice Program and immediate Past President of Hospice of South Carolina, Mr. Pass feels that he can adequately address the general concerns of Hospice Programs in this State.

The Hospice Licensure Act was signed into law by the Governor in March of 1983. DHEC subsequently developed a preliminary draft of proposed minimum standards for licensing Hospices.

In South Carolina the needs of the terminally ill have been addressed by the development of Hospice Programs. One of the cornerstones of the Hospice movement is the flexibility with which services can be organized and implemented by utilizing the resources that are available. Hospice care has developed to the stage now where licensure of programs is appropriate because 1) it protects the consumers of the service, 2) it provides consistency throughout the State, 3) provides credibility and sanction, and 4) entitles providers to receive Medicare reimbursement.

Hospice Programs focus on a small segment of the population, most persons will be over 50 years in age and have Medicare as their primary insurance coverage. Hospice serves a clientele on fixed income, with little or no resources and support systems that are weak or poorly defined.

Mr. Pass is certain that the proposed licensure standards were developed with an eye toward Federal assistance. However, not all programs will desire certification for Medicare reimbursement but many desire the sanction and protection that State licensure can provide. In his opinion, Hospice has always been a community oriented service. He urged the Committee not to adopt inflexible standards but to consider the adoption of standards with flexibility so that each community may provide the services based on their needs and the resources available to them.

Senator Rubin remarked that this being a new Program we can certainly adapt to reasonableness in it. He mentioned Mr. Alan Samuels, who was in the audience and, as Director of Health Licensing, has arranged several Public

Hearings on the proposed regulations to implement the Hospice Programs.

Mr. Samuels informed the Committee that the Board of Health approved revised proposed regulations. He assured Mr. Pass that the revisions had been substantial and that Mr. Pass will be very well pleased with them. The Hearings will be publicized and held in different parts of the State.

Senator Rubin added that the General Assembly, of course, has the power to reject regulations. DHEC regulations usually come to the Senate Medical Affairs Committee and staff will take a careful look at them.

JOINT LEGISLATIVE COMMITTEE ON AGING
PUBLIC HEARING
SEPTEMBER 23, 1983

COMMENTS REGARDING PRELIMINARY DRAFT - MINIMUM STANDARDS FOR LICENSING HOSPICES

DAVID S. PASS, ACSW
HOSPICE PROGRAM DIRECTOR
GREENVILLE HOSPITAL SYSTEM
GREENVILLE, S. C.

SENATOR RILEY
~~Mr. Chairman~~ and committee members, thank you for the opportunity to address you regarding the licensing of Hospice programs in South Carolina. As you are well aware on March 28, 1983, Governor Riley signed into law the Hospice Licensure Act, which was the direct result of the diligent work and unfailing support of the Study Committee on Aging and other members of the legislature. In an equally diligent and timely manner, the South Carolina Department of Health and Environmental Control Division of Health Licensing developed a preliminary draft of proposed minimum standards for licensing Hospices for comment and recommended changes. As the Director of a Hospice Program and immediate Past President of Hospice of South Carolina, I feel I may adequately represent the general concerns of Hospice programs throughout the State of South Carolina.

It is well documented that physical illness has significant social and emotional components. It disturbs the equilibrium and the resources, real and emotional, of the patient and the family. It produces tension in relationships, creates isolation, discomfort, increased dependency, uncertainty, and fear. Once an illness is identified as terminal, these problems and feelings are greatly magnified, and often overflow to the community.

Traditionally in the United States, dying has been dealt with on a non-organized basis by physicians, clergy, health care professionals, and others in the community, if it has been dealt with at all. Hospice focuses on providing organization and coordination in dealing with the difficult and sensitive area of death and the tasks that accompany the process of dying. Hospice is an attitude, a philosophy, and methodology of care which encompasses the patient with a life threatening illness. It is intended to provide sane, rational, compassionate family-centered care, with a primary goal of assisting the individual who has a terminal disease to live as fully and productively as possible through the provision of planned and coordinated services. At the heart of this effort are several critical elements:

1) the individual should be regarded as a person experiencing a natural, rather than an unnatural, process;
2) the individual has rights, including the right to be involved in decision-making processes;
3) the individual should be allowed the opportunity to die as they have lived -- family and friends expecially have roles as care providers;
4) the individual should be given the opportunity of achieving some level of acceptance of death, retaining as much personal integrity as possible, and not relinquishing all hope, which is the spark of living each day to the fullest.

In South Carolina, as in the rest of the United States, the needs of the terminally ill have been addressed by the development of Hospice Programs. The American tradition of self-determination has been preserved in the manner in which programs have organized to truly reflect the communities and the people they serve. One of the cornerstones of the Hospice Movement is the flexibility ~~in~~ with which services can be organized and implemented, utilizing the resources that are available to specifically address needs and concerns of that community.

Hospice is essentially a simple and straight-forward concept ~~that~~ provides appropriate medical care and stresses symptom control, ~~management~~ of pain (physical and emotional), provision of emotional support ~~to~~ the patient/family unit, respects and addresses spiritual/~~philosophical~~ needs of the patient/family unit, and provides follow-up bereavement care ~~after~~ the death of ~~the patient~~. The care is provided by teams of ~~professionals~~ and trained volunteers, and works to permit ~~the individual~~ to remain at home as long as possible or potentially avoid institutionalization altogether.

With the recent and continuing attention directed towards the soaring costs of hospitalization, communities have responded with the institution of Hospice home care services, utilizing inpatient beds only when absolutely necessary, to deal with the needs of a very special group of consumers. Hospice care has established itself as more than a transient fad or treatment modality. It has developed to the stage now, particularly in South Carolina, where Licensure of programs is appropriate for several reasons:

1) licensure protects consumers of the service. By being a licensed program the user can be fairly sure that specific services are available and that they are organized and delivered in a prescribed manner by appropriate persons;
2) licensure provides consistency throughout the state, irregardless of whether services emanate from a hospital, a community agency, or a free standing organization;
3) licensure provides a statement of credibility and sanction;
4) licensure is certainly necessary for those programs seeking certification as providers in order to receive Medicare reimbursement.

However, licensure standards and requirements should not inhibit or restrict the provision of services to those in need, nor impede the development of new programs by placing unrealistic or unnecessary requirements on newly formed groups. In like manner they should not penalize or inhibit existing programs from continuing to function.

Hospice programs invariably focus their services on a small segment of those persons needing medical services, the majority being elderly. In Greenville last year 88% of our patient population were age 50 or older; 61% had Medicare as their primary insurance coverage. These percentages are probably similar throughout the State. The inference is that Hospice serves a clientele who have little or no resources available to them. Income is fixed or non-existent, personal resources are close to being depleted, and support systems are weak or poorly defined. I am certain that the proposed Licensure Standards were developed with one eye on the Federal Government as it was proposing regulations for Hospice reimbursement with Medicare funds. However, licensure and proposed certification requirements should not be linked together unnecessarily. Not all programs will desire certification for Medicare reimbursement but may desire the sanction and protection that State licensure can provide.

State Licensure requirements should, then, protect and preserve the integrity of all existing programs and offer a set of guidelines for them and any newly forming programs to follow. The structure of Hospice services should be maintained, but flexibility be preserved in how a particular program organizes and implements those services to meet the needs of their communities.

Most importantly, Hospice has always been a community oriented service, from educating and enlisting community support and understanding to the use of trained volunteers from the community to the utilization and coordination of physician and agency services to provide the best mix of care to the patient and his family.

I urge you, in behalf of all Hospice programs and recipients of Hospice services, not to adopt stringent and inflexible standards for Hospice Programs. Rather, adopt thoughtful basic requirements for all programs, with the felxibility for each program to arrange for the delivery of those services in the most suitable manner for their community. This suggests that, whether the Hospice is community-based, agency-based, or hospital based, all program services can be provided via contract, cooperative agreement or directly under a central hospice program administration; that patients can retain their personal physician who works with the Hospice team; that effective use of trained community volunteers is perpetuated; and that Hospice programs and hospitals can continue to work cooperatively rather than become embroiled in contract disputes or conflicts over the hospitalization of Hospice patients.

The Hospice movement has breeched a gap in the community and has re-vitalized our concern and interest in our neighbor. Hospice has promoted cooperation among community groups that had been all but forgotten. Most importantly Hospice has provided one mechanism to express care and concern to those in need - the ill, the elderly, and the lonely. Please do not deny our citizens this service by enacting overly restrictive and inflexible requirements for Hospice Programs. Please consider the adoption of standards that provide for the integrity of Hospice Program structure and service, but with the utmost flexibility so that each community may provide the services based on their needs and the resources available to them.

Representative Ben Thraillkill,Jr., DDS, Member
National Advisory Council on Health Professions Education
Surfside Beach, SC

At their last Council meeting, a Resolution dealing with Humanistic Health Care was adopted, which Representative Thraillkill read to the Committee. He, also, gave a short background into the reasoning behind this Resolution. Since World War II, health related expenditures in this country have represented an increasing share of the national output. In the years ahead the demands of an aging population will drive the total expenditures upward. From all trends one can conclude that the health care industry's share of the gross national product will increase. This assumption is supported when one studies the demographics of the population. In 1950 health expenditures represented 4.5 percent of the gross national product, by 1978 that percentage was 9.1 percent.

The Federal government has been involved in the education of health professions for the last couple of decades. At first they aimed to increase the number of health professionals by granting "capitation" grants based upon enrollment increases. These grants, however, have virtually stopped due to the projected over-abundance of health professionals.

Now it appears that the next thrust with Federal grant monies to health professionals will be in the area of Gerontology and Geriatrics. Several pilot programs were authorized at the August meeting of the National Advisory Council on Health Professions Education which are designed to create several Geriatric Educational Centers in various parts of the country. These centers will be post-graduate educational centers for the care and concern for the elderly, and the majority of Federal health care educational dollars will be in this direction.

Senator Rubin remarked that he had been made aware of the fact that there are students and an instructor from Allen University in the class of Gerontology visiting. He asked them to stand so that they can be recognized. He said that this is a good place to learn about gerontology.

Dr. Parrish asked for an explanation of the remark made by Dr. Thraillkill concering the post-graduate educational centers. He wondered if they are excluding under-graduate levels or are they just aiming for top professionals at the graduate school level.

Representative Thraillkill replied that this is simply a pilot program, an initiation of concerns for the geriatric patient. There are only $1.5 million allocated out of the Federal budget to be used by doctors who have already graduated to give them additional training and information which will help them perform their professional functions in regard to the geriatric patient. This is on the national level. There will be about five centers throughout the United States funded by this $1.5 million.

Senator Rubin recognized Mr. Purvis Collins, Director of the S. C. Retirement System, and Mr. Bill Garrett, Director of Adult Protection, DSS.

House of Representatives

State of South Carolina

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Committee:
Agriculture and Natural Resources

September 19, 1983

Mr. Chairman and Members of the Study Committee on Aging:

As a member of the National Advisory Council on Health Professions Education, I thought the Committee might be interested in one of the principal subjects of our agenda at our last Council meeting.

During that meeting a Resolution dealing with Humanistic Health Care was passed. With your indulgence I would like to read that Resolution:

"WHEREAS, it is recognized one of the most pressing issues confronting both patients and health professionals is the depersonalization/demanization of health services, and

WHEREAS, it is recognized a complex health system is producing increased ethical considerations for health professionals, and

WHEREAS, it is recognized the ideal point of intervention to produce more humane and ethically aware health professionals is the basic professional education process, and

WHEREAS, a major factor in improving the ethical and humane training of health professional students is the development of faculty, especially clinical education faculty, to carry out their responsibilities as role models, educators and researchers.

Therefore,

BE IT RESOLVED, incentives and Federal support be directed toward increasing the knowledge and skills required in patient care that are ethical, compassionate, and designed to produce practitioners who can communicate effectively with patients concerning physical, psychological, social, and ethical aspects of health care.

BE IT FURTHER RESOLVED, a program of Humanistic Health Care be located in the Bureau of Health Professions of the Health Resources and Services Administration.

This Resolution was adopted by the Council.

To give you a very short background into the reasoning behind this Resolution is in order. The Federal government has been very involved in health professions education for the last couple of decades. The post-World War II 'baby boom' created a health care shortage in conjunction with the inception of Medicare and Medicaid.

Health related expenditures in the United States has represented an increasing share of the national output since World War II, driven primarily by rapidly advancing frontiers of knowledge and exploding demand generated by expansion of third-party payment mechanisms and governmental tax incentives. In the decades ahead, the demands of an aging population will add a new dimension to the forces already driving total expenditures upward. The demographics of the 1990's and beyond pose a challenge to our society which must be faced today.

The conclusion one draws when contemplating the future of health related expenditures in the United States is that the health care industry's share of the gross national product is likely to increase. This conclusion can be reached by examining the demographics of our population. Our society is growing older. As the post-war 'baby boom' ages into the 50's, 60's, and 70's, its demand for medical

care could grow dramatically. Persons between the ages of 19 and 64 spent 2.6 times as much per capita on medical care in 1977 as those under 19. More importantly, persons 65 and over spent 2.6 times as much as the 19 to 64 group.

In 1950 health expenditures represented 4.5% of the gross national product. By 1978 that percent of the gross national product taken by health care had reached 9.1%. If our society is beginning to feel that 9% of the gross national product is approaching the limit as to resources it is willing to allocate to health related activities, the potential for conflict in the decades ahead are very great. An attempt to hold the line at 9% must include rationing of care, which will put a great burden on those asked to do the rationing. If we decide as a society that all medical knowledge and technology must be available to everyone, we will of necessity have to be willing to allocate greater and greater resources to this industry at the expense of other industries. If we are unwilling to do this, we must begin setting up the mechanism to limit that care.

At first the Federal role was one of increasing the number of health professionals, this being accomplished by extending a "carrot" to professional schools in the form of 'capitation' grants based upon enrollment increases. In recent years these 'capitation' grants have virtually ceased due to the projected over-abundance of health professionals. All new funding grants are based upon demographics or categories of services. As an example, family-practice residences have received the lion's share of grant monies in the last five years; however, that practice will soon become a thing of the past.

It would appear that the next thrust with Federal grant monies to health professions will be in the area of Gerontology and Geriatrics. Several pilot programs were authorized at our meeting in August -- programs designed to create several Geriatric Educational Centers in various parts of the country. These Centers will be post-graduate educational centers designed to emphasize the care and concern for the geriatric patients. In the months and years ahead the majority of Federal health care educational dollars will be in this direction.

Thank you, Mr. Chairman and the Committee, for the opportunity to apprise you of this new direction in Federal intervention in health care for the elderly.

Mr. Edwin C. White, Chairman
AARP, S. C. State Legislative Committee
Rock Hill, SC

The State Legislative Committee has been reviewing the responses of a sample of elderly South Carolinians to a questionnaire. Some of the concerns have been brought to the Study Committee on Aging's attention before, but the AARP is asking for redoubled efforts for relief of the following issues:

1. Control of the escalating costs of health care has the highest priority. Again, they ask to have a hospital rate review board set up or that other innovative approaches be considered.

2. Continuation of the cost-of-living increases in pensions for retired State employees and retired teachers.

3. They ask that 1984 will be the year for passage of the long-needed reform of the S. C. Probate Code.

4. They ask for legislation to assure elderly persons access to health care services under Medicare.

5. Increase of the Homestead Tax Exemption from $15,000 to $30,000.

In addition to these issues there are three other items which the AARP membership supports:

1. Provision of incentives for families to help them keep their older relatives in their homes in the form of financial assistance, tax breaks and support services, such as adult day care centers and transportation.

2. House Bill H-2364, a Bill to Establish a Program of Community Services for the Functionally Impaired Elderly.

3. Continuation of efforts to place more older consumer representatives on licensing and regulatory boards and commissions.

4. Mandatory penalties upon conviction of driving under the influence also in cases which do not result in bodily injury.

Representative Blackwell wanted to know if the organization has taken a position on the Governor's possible proposal to increase the sales tax by 1 percent for education.

Mr. White told him that they have not yet taken a position but expect to take one as this issue develops.

Dr. Holler pointed out that there are 432,000 people in South Carolina above 65 years of age and that there are about 103,000 who belong to the organization represented by Mr. White. Further he stressed the fact that those over 60 represent from 40-50 percent of the voters in the precincts and counties of this State.

(Newspaper clippings which were submitted by Mr. White in addition to his testimony are on file in the Committee.)

Statement before the Joint Legislative Committee on Aging
on behalf of the AARP South Carolina State Legislative Committee
by Edwin C. White, Chairman, September 23, 1983.

Our Committee has been pleased to note the continuing concern of the Members of the General Assembly and the Governor of South Carolina for the welfare of elderly South Carolinians as evidenced by the passage of a number of pieces of legislation. These are enumerated in the annual report of your Committee so I will not review them here.

As in past years our AARP Committee has reviewed the responses of a sample of elderly South Carolinians to a questionnaire. As a result we can state the legislative issues of most concern to them this year. You will note that these are issues that have been brought to your attention before, and that they have been the subject of continuing study by Members of the General Assembly. We ask for redoubled efforts toward relief of the problems highlighted.

1. Of highest priority is control of the escalating cost of health care. I am sure that what I have to say in support of this need is already well known to you:

Last year, medical costs nationally rose twelve percent over the previous year, more than three times as fast as the consumer price index. In South Carolina the rise has been even steeper; in the last five years it has more than doubled according to George Johnson, Vice President of Blue Cross and Blue Shield of South Carolina. But the Federal Medicare program has put into effect each year, regulations to cause this program to cover a diminishing part of the cost of health care services. The deductible for a hospital patient was raised twenty-seven percent in 1982 and another seventeen percent in 1983. Now the Medicare program is going to reimburse fixed amounts for specifically defined illnesses and treatments, regardless of the amount the hospital charges the patient.

Prudent elderly citizens, who are able to do so, have purchased medical insurance to supplement Medicare. Some participate in group plans sponsored by their former employers. But hospitals turn this prudence to their own advantage by "cost shifting", inflating the bills of paying patients to recover the money lost caring for patients whose government benefits don't cover the cost of services. Inevitable effects are increases in insurance premiums and deductibles.

It is clear that the disposable income of elderly citizens is being progressively reduced year by year by these escalating health costs. We ask that your Committee intensify its research in the field of health care cost control and take the lead in proposing and supporting measures to give relief. You are aware that one proposal is to set up a hospital rate review board to require hospitals to comply with rates set as a result of budget cost reviews. Consideration of other innovative approaches is called for.

There are other items of concern to elderly South Carolinians:

2. We ask continuation of the cost-of-living increses in pensions for retired state employees and retired teachers.

3. Reform of the South Carolina Probate Code has been under study for too many years. The reform bill was referred to the Judiciary Committees of the Senate and the House in April. We ask that 1984 be the year of passage for this long needed reform.

4. The access of many elderly persons to health care services has been limited because many physicians and other health care providers will not accept assignment of Medicare benefits. Since these providers operate under state license, we ask for consideration of legislation to assure elderly persons access to these services without discrimination based on method of payment.

5. The increase in property taxes this past year reduced the proportionate protection previously afforded to elderly homeowners through the $15,000 homestead exemption. We ask that this exemption be increased to $30,000 or that other appropriate measures be taken to restore the proportionate relief intended for elderly homeowners when the original homestead legislation was passed.

I have outlined to you our five Legislative Priorities for 1984. In addition there are three other items which we support:

A. We ask that incentives be provided for families to help keep their older relatives in their homes, and thus defer or prevent their transfer to institutions. These incentives could take the form of financial assistance, tax breaks or credits, and support services, such as adult day care centers and transportation.

B. We continue to support the program to place more older consumer representatives on licensing and regulatory boards and commissions.

C. Elderly citizens as well as many members of the general public in South Carolina have expressed continuing concern about the operation of motor vehicles by persons under the influence of alcoholic beverages or other intoxicating substances. We note with approval the enactment of bills R198 and S194 to provide mandatory penalties in case bodily injury results from such operation. We feel, however, that a stronger deterrent is needed and ask consideration and support for mandatory penalties upon conviction of driving under the influence also in cases which do not result in bodily injury.

We look forward to continuing our cooperation with your Committee and asssure you of our support and interest.

Edwin C. White, Chairman
310 Country Club Drive
Rock Hill, S. C. 29730
Phone: 327-2314

Reverend I. DeQuincey Newman
Columbia, SC

Reverend Newman spoke in behalf of the growing number of senior citizens in the State.

He said that much of what is in his submitted testimony has already been stated but he wanted to reiterate the fact that national and State statistics clearly indicate the tremendous growth rate of persons over 65 years, with a veritable explosion in the category of the very old.

He urged the Committee to continue its strong commitment to the critical area of long term care needs for the elderly and disabled. The time is now to develop statewide policies to provide in-home and community services for the elderly.

Senator Rubin thanked Reverend Newman for appearing. "The good news is that so many more of us are living to be older, and the price is a lot of problems."

Statement To: The Joint Legislative Committee on Aging

Presented by: I. DeQuincey Newman

Date: September 23, 1983

Time: 10:30 a.m.

Place: Room 101/109 Blatt Building, Columbia, South Carolina

Mr. Chairman and Members of the Committee, I first want to thank you for giving me the pleasure of appearing before you at this "Hearing."

I would take this opportunity to convey some specific concerns which I believe we hold in common with regard to our State's older citizens.

My appearance here today is a demonstration of a long standing and continuing interest in policies and programs relating to the needs of the elderly. My first concrete input in this area was membership of the first Legislative Committee to study the Needs of the Aging appointed by Governor John C. West and chaired by then Senator Richard Riley of Greenville and now Governor of South Carolina.

Both, Senator Rubin and Representative Harris the distinguished Chairman and Vice Chairman were original members of this honorable Committee.

During the early years of this committee issues advocated included property tax relief, improved health care and increased access to social support services for the elderly. During a period of progressive development you rose to the occasion and provided the leadership for meeting these needs. The Homestead Exemption Act for the elderly is one of the milestones you achieved early in the history of this Committee.

I come before you this morning not so much as a former member of this Committee nor as Chairman of the Governor's Rural Development Council but as a member of our State's Community of older Citizens.

National and State statistics clearly indicate a tremendous growth rate of persons over 65. Persons over 65 in S.C. grew over 50% during the last 10 years. The population over 85 grew by over 169% over the last 20 years. There is a veritable population explosion taking place in the "very old" category.

Today, we urge sound professional planning in order for our State to perform at the highest possible level in preparing for the needs of its elderly citizens.

S.C. has already moved out front in planning for the long term care needs of our elderly and disabled. We urge this Committee to continue its strong commitment to this critical area. Through the many advances in medical technology and geriatric research the elderly will remain healthier long. But we must be mindful of the rapid growth rate of the last 20 years and recognize that this rate of growth will continue well into the 21st century. The very old, as I indicated earlier, are increasing at an even more disproportionate rate. The time is now to develop and promote sound statewide policy which provides for the elderly through community and home based services.

The expenditures for nursing home care have greatly increased since 1973, and if present utilization rates continue the total nursing home population may increase by over 54% in the next 20 years. We must continue and increase our efforts to provide services to long term care clients in their homes and communities for as long as possible.

Ms. Lynn Frederick, Program Director
Health Impaired Elderly Project
Community Care, Inc.
Columbia, SC

This statement gave a brief update of the Health Impaired Elderly Project, which began in 1980 with funding by the Robert Wood Johnson Foundation. They are beginning their fifth and final year of the Project in February of 1984 at which time the functions of this program will be phased into the Central Midlands Regional Planning Council, Area Agency on Aging. This will ensure the continuation of the program in the future.

TESTIMONY TO THE

SOUTH CAROLINA STUDY COMMITTEE ON AGING

by Lynn Frederick
September 23, 1983

I would like to give a brief update on the Health Impaired Elderly Project today.

The Health Impaired Elderly Project began in February 1980, with funding by the Robert Wood Johnson Foundation through the South Carolina Commission on Aging and the Central Midlands Regional Planning Council. The goal of the project is to develop a community based network of coordinated services for older persons with health impairments. Approximately 20 agencies in the Colunbia Area are working together to achieve this goal.

The activites of the project are focused in four areas:

1. Comprehensive Assessment of Needs - Participating agencies have implemented an assessment process that identifies the full range of strengths, problems, and needs of older persons.
2. Sharing of Information Among Agencies - A central clearinghouse of assessment information has been established which facilitates coordination of services, reduces the amount of duplicate efforts spent in assessing the needs of the health impaired elderly and provides a comprehensive data base for planning future services.

   There are now over 2,800 health impaired elderly clients in this client information system.
3. Case Coordination - Case Coordination Teams have been set up in both Richland and Lexington counties. Representatives of participating agencies meet regularly to discuss clients who have multiple agency involvement or who could benefit from coordinated service management.

(cont'd)

4. Informal and Volunteer Support Services - The project works actively to support infomal caregivers (family members, friends, neighbors) to help them meet the needs of older persons. Identification, training, and support of volunteers to work with the elderly are also ongoing activities.

   Handbooks for volunteers who work with the elderly are being written and will be printed by early 1984.

We are now entering an important phase of the project. We will begin the fifth and final year of our project on February 1, 1984. At that time the functions of the program will be phased into the Central Midlands Regional Planning Council, Area Agency on Aging.

This will ensure the continuation of the program in the future. The Area Agency on Aging staff is doing an excellent job of preparing to assume these functions. I am excited that they are willing and able to do this.

This program id demonstrating that local agencies can and will share information and work together to coordinate services at the grass roots level. I hope that this program will provide input for state and local policies which relate to the health impaired elderly for many of the aspects of the project can be replicated at minimal cost but with great benefits to the elderly.

Mrs. Joan S. Kershner, Director
Wm. Jennings Bryan Dorn Veterans' Hospital
Columbia, SC

This testimony addressed the growing concern of the Veterans' Hospital regarding the care of the "total care patient."

She cited examples of patients who cannot be referred anyplace else because no one can care for them. This is the kind of patient who no longer needs acute care; i.e., he has come to some normal level of care and either will be referred to total nursing care or referred home.

There are a variety of levels of care. The acute care bed--whether it is in the private sector or in the public sector of the hospital--is for that kind of patient. The new DRG (diagnostic related group) mechanism of reimbursement will be based on the acute care bed need. Often elderly patients come in for acute care (with a cardiology or hip problem), and they deteriorate for whatever reason--a percentage will do that. The patient will be stabilized at the acute care level and referred to another level of care, usually less expensive. However, it is more and more difficult to place these patients out of an acute care level and into another level of care, because it requires a tremendous amount of skilled nursing care on a closer to 1:1 basis and rarely is an institution able to do this.

As these kinds of patients develop throughout the State, you will be hearing more and more of the problems relating to families caring for these patients.

In the VA, they address their first needs to the service-connected vets. They have 120 nursing home care beds, and they are filled. Normally VA takes the service-connected vets first (these are usually considered World War wounded), but they also have the nonservice-connected vets who may have received a disability or injury during a period of service and have been adjudicated. The nonservice-connected vet only, by law, can be cared for within their resources. If the beds at the VA are filled, they return these patients to their private doctors for care.

Senator McLeod questioned why a skilled care nursing home cannot take care of someone who is being tubefed.

Mrs. Kershner replied that they can only take care of a certain percentage. However, these patients require every care of daily living needs. Right now

all of the skilled nursing care homes have a staffing criteria, most of them meet this criteria, but they will have to have additional staff. Seventy percent of the 120 beds are usually Category I, or this "total care patient." But if you fill up 100 percent, even VA is not staffed for that. At the VA nursing home they try to mix in patients who have rehab potential so that they can turn over and touch more veterans. "Otherwise, you put this kind of patient in and 120 patients are in the bed, and they are there till they die. You must have some kind of turnover." Community nursing homes are faced with the same problem.

Senator McLeod assumed that it is really more a problem of the nursing home not being able to afford to take them rather than not wanting them.

Mrs. Kershner agreed with this assumption. Another problem is that it is not always easy to find staff who will take care of a 100 percent total care patient. She added that she just went to a meeting of all the Medical District Directors (Atlanta, Augusta, Dublin, GA, Charleston and Columbia), and they all have the same problem. There is a growing need in today's population in general, and she feels that the Legislature will be pressed into some kind of consideration in the future.

Senator Rubin recognized Reverend Dial, representing the Ministerial Alliance of the Black American Churches in the Midlands area, and Ms. Yvonne Simpson, Aging Director of the Appalachian Council of Government.

(Note: A letter of confirmation of this presentation is on file in the Committee).

Ms.Emilie Towler, President
SC Gerontological Society
Aiken, SC

The South Carolina Gerontological Society was organized in 1978 and now has 200 members representing many different areas of expertise as well as specific involvements in the field of gerontology. Their mutual concern is to promote the welfare of older people in South Carolina.

They are enthusiastic about the $1 million bequest to MUSC for the establishment of the McKnight-Boyle Chair in Gerontology, which was made in 1976. They are following the development of this endowment through Dr. James Allen, Chair of the Department of Medicine.

Several southern states have already established Gerontology Centers, and Alabama and Georgia are notable examples. Now South Carolina has the capability through the McKnight-Boyle endowment to be a leader in this field. Professor Towler suggested to the Committee to enact legislation to establish offices of gerontology and/or geriatric medicine at state-supported medical schools. In her opinion immediate steps should be taken to start gerontologial research and training at MUSC where the funding is now available.

The Society also asks, through this Committee, for a progress report from MUSC on the present state of implementation of this gerontology program.

Senator Rubin assured Professor Towler that he will follow the development of this program closely as he was a member of the Board at MUSC. The position taken up until now was not to fill the Chair until funds for supporting efforts were available. This can now be accomplished with the $375,000 recently allocated.

Professor Towler said that they have not come before the Committee to push the program immediately; however, they thought that the money was accruing some very nice interest over the years. Their hope is that it can be implemented very soon.

Dr. Holler asked what the Committee can do to help speed up the implementation.

Professor Towler referred to legislation enacted in Ohio, where the Legislature required medical universities supported by the state to have a Department, a Chair, a Division of Gerontology.

Comments by Professor Emilie A. Towler, President of the South Carolina Gerontological Society, before the Study Committee on Aging of the State of South Carolina on Friday, September 23, 1983.

Senator Rubin and Members of the Committee

Thank you for the privilege of appearing before you today as President of the South Carolina Gerontological Society. The S.C. Gerontological Society was organized in 1978 as an umbrella organization to bring together educators, researchers, service providers, policy planners, and active retirees in our state. Members of the Society represent many different areas of expertise and specific involvements in the field of gerontology. We are united in our mutual concern to promote the welfare of older persons in the State of South Carolina. We are also affiliated with the National Gerontological Society of America.

Three primary aims of the Society are:

1. To initiate, stimulate and encourage action in promoting or developing facilities and/or programs to meet the needs of older people.
2. To act as a medium for communication and to afford a common meeting ground for everyone concerned with the field of aging.
3. To work cooperatively with any group, organization or individual in expanding services, programs, education and research in the field of aging.

We have read with great enthusiasm the publicity attendant upon the bequest of $1,000,000 given to establish the McKnight-Boyle Chair in Gerontology at the Medical University of South Carolina. This bequest was made in 1976. We have kept up to date as much as possible on the development of this Endowment through the report of Dr. James Allen, Chair of the Department of Medicine, to this Study Committee at your Hearing in September of last year.

We are aware of the support services which are necessary to augment the effectiveness of a gerontologist appointed to this chair, such as research space

and funding, in-patient and out-patient clinical facilities, additional salaries for support personnel to staff effective teaching and research programs. We realize additional funding sources will have to be acquired. We applaud the efforts already made by the Medical University of South Carolina to develop a carefully conceived and executed comprehensive program which will include research in both biological and psychological aspects of aging and in teaching of gerontology at both undergraduate and graduate levels at the Medical School.

The S.C. Gerontological Society's over 200 professional members want to state their strong support for the establishment of a Gerontology Center in a University setting in this state. We are eager to see the fragmented efforts now in effect organized into a vital and progressive entity. We wholeheartedly support use of this Endowment and implementation of this program with all possible speed.

State Universities in several of our sister southern states have broad-based Gerontological Centers actively engaged in both research and education — Alabama and Georgia being notable examples. South Carolina has the capability and the initial impetus through the McKnight-Boyle Endowment to be a leader in the field.

Can legislation be proposed, enacted and supported under the auspices of this Legislative Study Committee to bring this program to reality? We are informed that a number of states have enacted legislation to establish offices of gerontology and/or geriatric medicine at medical schools supported by the state. This legislation expresses to the medical schools the concern for gerontology research and teaching on the part of the citizens at that state. We suggest and request this in order to move this program to implementation. We believe that this project is of such compelling importance to the citizens of this state that immediate steps should be taken to activate gerontological research and training at the Medical University of South Carolina where the funding is now available.

The Society requests, through your Study Committee, a progress report from the Medical rsity of South Carolina on the present state of implementation of thi ntology program.

Dr. Hilda Ross, Director
Mental Health Services for the Aging
Department of Mental Health
Columbia, SC

Dr. Ross told the Committee about the S. C. Department of Mental Health's new program that addresses the release of patients to the community. In the past, this process was called "deinstitutionalization." This term is no longer used and today a different concept is addressed. The Department is moving toward a comprehensive program which will provide rehabilitation and treatment through a range of clinial and support programs.

In 1981, DMH created a Committee to study what was needed to set up a comprehensive community support program, both in the hospitals and in the Community Mental Health Centers. The result was for DMH to create a separate Community Support Program Task Force, and a Community Support Program Office was officially designated in 1982. It is operated under the supervision of the Assistant State Commissioner. This Office is responsible to 1) plan and implement a single continuum of care between the hospital and the community, 2) enhance emergency care in the communities, 3) allocate money for these services, and 4)monitor and evaluate all the services.

A screening process performed by the Community Mental Health Centers/Hospital identified 531 patients--279 from Crafts Farrow--who will be returning home. Each county will receive a certain number of people, the largest counties about 17 people. The new Community Support Programs can adequately serve this population and the clients who are already living in the community.

To accommodate this shift to the community there will also be an equitable shift of money and personnel from central facilities to the community. In addition, every time one of these 279 designated persons leaves the hospital, $20 per day follows this person into the community. Two other funding resources are: $2.8 million has been earmarked to implement intensive crises treatment (Emergency Stabilization Program) in the community and an additional $900,000 will go to CMHC to replace lost Federal dollars.

Dr. Ross cited two typical cases of people returning to the community which are described in her testimony on the following pages. The comprehensive care these people are receiving shows that DMH is providing a continuum of care.

In closing she describes how in the various parts of the State CMHC's, communities and volunteers work together in a climate of acceptance to help this type of population.

Senator Rubin expressed his appreciation and called the report encouraging. It summarizes a lot of problems on all levels.

Dr. Parrish added that "this is a revolution!"

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
Columbia, S. C.

Senator Rubin, members of the Study Committee on Aging, I am here to tell you about the South Carolina Department of Mental Health's (SCDMH) new program that addresses the release of patients to the community. The word used to describe this process is "deinstitutionalization" and it comes with a range of connotations; the word means "moving patients out of the hospital". In the past decades, it did not imply current concepts of "community care" as we want it practiced today. It had been that State Psychiatric Hospitals populations in the late '60's and early '70's were reduced from 6500 patients to 3200 patients. Today the resident population is 2600. During this time programs for providing care after hospitalization were known as "aftercare". This included monitoring the person's medications and socialization. It was an efficient way of working with large numbers of clients in Community Mental Health Centers with limited staff and resources. All this is in the past now. "Deinstitutionalization" is no longer used in psychiatric nosology. Today we are addressing a very different concept. The SCDMH is aggressively moving toward a comprehensive program whose intent it is to provide rehabilitation and treatment through a range of clinical and community support programs. This is far more extensive than earlier "aftercare".

WHAT HAS OCCURRED SO FAR

In 1981, the Department of Mental Health created a Committee to study what needed to be in place both in the hospitals and in the Community Mental Health Centers for a comprehensive community support program. The major priority that came out of this Committee was for the Department of Mental Health to create a separate Community Support Program Task Force. As a result of demonstrated need, the support of the General Assembly, the Governor's Office, and the recommendations, a Community Support Program Office was officially designated in 1982. It has 2 full-time employees and one part-time employee. The new office was placed under the supervision of the Assistant State Commissioner. With this action, the State had an identifiable administrative unit to (1) plan and implement a single continuum of care between the hospital and the community, (2) to enhance emergency care in the communities, (3) to allocate money for these services, (4) to monitor and evaluate all the services.

At the same time, a major joint effort by the CMHCs and hospitals had been in progress. Staff from the CMHCs and hospital staff have been examining the status and needs of the chronically mentally ill patients who might be candidates for discharge. Once the patients were identified, the CMHC staff needed to determine if there were sufficient center staff to assist these clients in the community; to determine how to make the best use of available community resources, and the opportunities for the clients; to identify services not now in place; to determine the range of housing alternatives; to review the clients network of social supports that included friends, neighbors and family, if there was one. In fact, the CMHCs were in the first stage of moving toward a multi-faceted comprehensive system of care within the mental health system that necessarily included other agencies, state and local providers and the people in the community. Clearly the needs of clients far exceeded what the SCDMH could do alone or what any one agency could do. A cooperative community thrust was unquestionably needed.

HOW MANY PATIENTS ARE WE TALKING ABOUT?

Of 531 patients identified as a result of a joint Community Mental Health Centers/Hospital screening process, 279 are from Crafts Farrow who will be returning home. This will result in 4 people going to one county, some counties may receive 7 people, others 8 or 10 people, and the largest counties perhaps 17 people. The development of the new Community Support Programs would more than adequately serve this population and the clients who are already living in the community.

WHERE IS THE MONEY COMING FROM:

There will be an equitable shift of money and personnel from central facilities to the community. Every time one of the designated 279 leaves the hospital, $20.00 per day from hospital funds follows that person into the community. In addition to utilizing this money, two other funding resources are available. $2.8 million has been designated to implement intensive crises treatment (Emergency Stabilization Program) in the community; in addition the CMHC will receive an additional $900,000 to replace lost Federal dollars.

TWO CASES TYPICAL OF PEOPLE RETURNING TO THE COMMUNITY

1. A 70 year old female midget was identified for return to the community. She is a soft-spoken, gentle person who had experienced depression. In order for her to enter the boarding home, she needed a special bed and a walker. Assistance came from the CMHC and Medicaid. When she asked that a friend she had made at Crafts Farrow, also scheduled to leave, be placed with her, this was arranged by the hospital and center staff.

In the community: She receives minimal medication with continuous monitoring from the CMHC. This particular boarding home contracted with a physician to be on call and he is seeing her for severe arthritis and high blood pressure.

ADDITIONAL SERVICES: The CMHC staff and the home operator concurred that the other residents needed a close friend, too. The CMHC has already recruited volunteers, training is scheduled and they will be assigned to residents in the home.

2. A 57 year old male experienced acute deafness for the first time. The episode brought a change in his behavior that resulted in admission into Crafts Farrow. He was recently discharged. Although he lives close to his family, he remains excessively fearful in his strange silent world. In addition to deafness, his major medical problem is acute liver failure which is terminal.

In the community: Community Long Term Care provides assessment; CMHC provides counseling to the family and to the client, DHEC provides a home health nurse 2 days/week,and through Commission on Aging a homemaker comes in daily from 10 to 2. The CMHC Geriatric Specialist and the COA social worker are working on securing the following additional services that a team of agency personnel agreed would be necessary to keep him in the community.

1. Training for the deaf;
2. a male volunteer who can become his friend;
3. a medical day care program;
4. with transportation, he could go to a Senior Center;

and respite for the family all of whom are much older and not well themselves.

The full comprehensive system is not in place; however, the commitments toward that system of care have been taken:
There are three:

1. The Department made a commitment to policy that it will maintain the chronically mentally ill client in the community.
2. The Department made a commitment to money. There is a financial system in place that ensures health care and emergency care to the mentally unwell people.
3. The Department made a commitment to action. There is a new separate office designated with authority and responsibility to administer a program that will assure comprehensive care.

WHAT IS HAPPENING IN THE COMMUNITY NOW?

In the western part of the state, volunteer groups are formed by churches and Mental Health Associations to work with the returning patients. A volunteer will become the single supportive person for the individual living alone. Another CMHC is developing a Neighborhood Family, a psychological and social model in which the elderly clients assume leadership and responsibility for their own services and programs; another center is identifying the primary health care providers in their counties and especially the physicians who will work with the Medicaid/ Medicare clients. In the central counties, centers are organizing residents who will provide ancilliary community services; another center is providing specialized training for center staff; another, training for families caring for older unwell relatives at home. One is offering training to boarding home operators. To the south and east of us, centers have identified agency resources and are bringing professional staff together to develop services that are needed to serve this population. Most of the centers are making major managerial changes and are hiring skilled staff that will allow for additional services in emergency care.

A climate of acceptance to work with the chronically mentally ill from the residents and agencies of South Carolina is clearly evident and we have reason to feel optimistic with the initial thrusts.

Mr. Arthur J. H. Clement, Jr., State Coordinator
Citizen Representation Program, AARP
Columbia, SC

He informed the Committee that they are not asking for money or the establishment of an agency, all they are asking for is to give consideration to that large segment of the senior citizen population that is alert and anxious to be of service in this State.

He favorably mentioned the School of Gerontology which Mr. Harry Bryan, Director of the Commission on Aging, has conducted for the past seven years. He asked that the Legislature assist the Commission with this process.

He referred to a list of upcoming vacancies on South Carolina Boards and Commissions, dated May 1983 and published by the Study Committee on Aging. He urged the Committee to use their influence in helping senior citizens get appointed, especially to boards and commissions dealing with health related matters.

Texas, North Carolina, New Mexico, Illinois and Louisiana have already passed Resolutions requesting the Governor and Legislature to consider appointments of elderly citizens to state boards and commissions in equal proportion to their population within their respective state.

(Enclosures to Mr. Clement's statement are on file in the Committee).

Senator Rubin assured Mr. Clement that they are behind him on this and what is needed is a continuing educational approach.

To:Joint Legislative Study Committee on Aging
Blatt Building-----Columbia,S.C. 9/23/83

From:Arthur J.W.Clement,Jr.,State Coordinator
American Association Retired Persons'
Citizen Representation Program

Again,we want to thank you for giving concerned citizens this opportunity to present their interests and hopes and it is our sincere trust that even though you receive a multiplicity of requests and suggestions,you will be amply dedicated to your elected responsibilities and take the time to give the proper priorities to these various matters. This is the democratic process and we value this opportunity for communicative interchange.

I would like to repeat a statement that I made last year since from a statistical point of view--it is more significant this year than when I made it last year:The some half million citizens in South Carolina who are senior citizens find their ranks increasing and this trend will likly continue for several years. Many of these persons are in nursing homes.Others are in senior citizens housing/residential complexes that are springing up in various sections of our state in significant numbers. Keep in mind that if you,who conduct this hearing,live long enough you are going to join this segment of our population. While you still have time,influence and appointive powers you can take a tremendous step to insure,to guarantee that generations of elder South Carolinians who preceded you---as well as those of your peers will have the stimulating opportunity to continue to be useful and worthwhile members of their communities. The power for granting this type of utilization of these senior citizens lies to a great extent lies within your and your fellow legislators' power and decision. Study by various authorities of the art and science of growing older strongly indicate that fear of aging,often far more than the actual aging itself,with its possibilities of inactivity,being abandoned by younger and more active family members--can hasten the ravages

of reduced self-image, self-respect, self-importance and hurry the previously alert, active, busy, involved individual into a self-defeating closet of isolation, introspection that hurries the individual toward illness, nursing-home care and total dependence. We beg your Committee, while there is still time, to take a very definitive look at your aging population and pledge yourselves to come up with some ideas and solutions that while medical science is finding ways to help mankind live longer---you will come up with doing all possible to make this living longer a more abundant life for the individual and more fruitful for the community and society as a whole.

Nursing homes and senior citizens housing/residential complexes are not the most viable solutions to caring for the elderly and many states are deciding and determining this. For the past seven years that South Carolina Commission On Aging, under the direction of Harry Bryan and the highly qualified staff that he has put in place has conducted a School of Gerontology that is taking realistic and innovative evaluations of what can be done to make South Carolina's aging citizens more productive and better able to cope in their senior years. You with your appointive powers can help wonderfully in this process.

Thousands of elderly South Carolinians are physically and mentally alert retired business executives, Armed Forces skilled retirees, trained college and secondary school administrators, professors, teachers, agricultural, vocational and technical retirees with years of constructive experiences and practical information that our state should be utilizing on public and private councils, boards and commissions. We have placed in front of you a list of upcoming vacancies on South Carolina Boards and Commissions. We urge you to look at this list and then look amongst your senior citizen constituencies. We feel certain that you are mindful that senior citizens are the most consistent voters in our state. They should have your considerations when appointments are available, especially on Medical, Hospital, Pharmacy and Long Term Care Boards, plus State Health Care and Home

Health Coordinating Councils. Texas, North Carolina, New Mexico, Illinois and Louisiana have already passed resolutions requesting the ~~ØXØØØ~~ Governor and Legislators consider appointments of elderly citizens to state boards and commissions in equal proportion to their population within that state. We have placed copies of such Resolutions in front of you. I am certain that you would not want our great and beloved state of South Carolina to do less by its senior citizens.

Today we are forwarding the name of Mr. Lester Hamilton, retired County School adminsitrator, to Governor Richard Riley suggesting his appointment to the State Pharmacy Board. We are certainly hopeful this nominee will have your interest and support.

The South Carolina Chamber of Commerce publication CHAMBER BEAT carries a list of openings on business related S.C. Boards and Commissions which indicates that the general public is becoming more conscious about our boards and commissions and the persons who are appointed to them. It is our conviction that legislators are going to have to be more circumspect, more astute intheir selections of nominees for boards and commissions. We are pleased to report that the American Association of Retired Persons in its Citizen Representation Program join you in your efforts to select only qualified persons, rather than place political expediency as the one and oly criteria for such selections for appointments.

Colonel Byron E. Long, USAF Ret.
S. C. Council of Chapters
The Retired Officers Association
Charleston, SC

This testimony addressed the matter of State Income Tax equity for pensioners. Colonel Long emphasized that he was not just speaking for the 6,000 members of the National Association here in South Carolina, but rather for the more than 36,000 retirees and annuitants from the Uniformed Services who live in this State. In addition, they are working closely with the South Carolina Federation of Chapters of the National Association of Retired Federal Employees (NARFE) with about 24,000 Civil Service annuitants in the State. Their legislative objectives are the same.

There is a gross inequity in the State income tax laws, since all retirees from the S. C. Retirement System are exempted from paying state income taxes on their pension income, whereas pensioners from Civil Service and the Uniformed Services and other pensioners are required to pay state income tax on their pension income. The unfairness of the current income tax law is further substantiated by the fact that many State, county, and municipal jobs are actually paid for by Federal funds.

Code 12-7-565 of 1976, gives the State permission to enter into reciprocal agreements with other states to refrain from taxing retirement income. Under this authority, reciprocal agreements have been established with 19 other states.

Colonel Long believes that the exemption of $1,200 for Federal Civil Service retirees, Armed Forces retirees aged 65 and over should be revised upward. In the case of military retirees he noted that 37 of the 50 states, and all of the Southeastern states, offer a better state income tax law than South Carolina.

While it is difficult to establish a formula for equity between retirees from the S. C. Retirement System and others, Colonel Long feels that they can arrive at a modification to the tax code that will be just for all concerned and with an acceptable fiscal impact. The Organization plans to file a bill to this effect in the early days of the 1984 session.

Representative Waldrop wanted to know the cost of this program.

Colonel Long informed him that a statement prepared by the Tax Commission--

based on a $5,000 exemption--puts the amount at $2.3 million. They are negotiating right now and are trying to get a $6,000 exemption, which would put the cost of the program at approximately $2.5 million. He hoped that the Committee would see the principle involved in this. There are currently 64,000 State employees, and he does not think that includes the municipal and county employees, and they are all going to be in this pool that is exempted once they reach the retirement qualification. They will not pay taxes, and he thinks this is wrong.

Senator Rubin reminded Colonel Long that over the years these employees have put in a good bit of their own money toward retirement.

SOUTH CAROLINA COUNCIL OF CHAPTERS

THE RETIRED OFFICERS ASSOCIATION

Presentation to the Joint Legislative Study Committee
On Aging, Blatt Building, Friday, September 23, 1983

SUBJECT: State Income Tax Equity for Pensioners

Senator Rubin and distinguished members of the Joint Legislative Study Committee on Aging, thank you for the opportunity to present this statement on behalf of our constituency. I am Colonel Byron E. Long, United States Air Force Retired, and I am President of the South Carolina Council of Chapters, The Retired Officers Association (TROA). We have eleven member chapters in our Council in such locations as Spartanburg, Myrtle Beach, Columbia, Charleston, and Hilton Head Island, with over 6,000 individual members of our National Association here in South Carolina. However, I would like to emphasize that I am speaking not just for the members of our organization, but rather for the more than 36,000 retirees and annuitants from the Uniformed Services who reside in this State. We are taking the lead on behalf of these retirees and are confident that we will have the active support of such organizations as the Air Force Sergeants Association, the NonCommissioned Officers Association of the USA, Navy and Coast Guard Petty Officers associations, and others.

In addition, and this is a major development, we are working closely with the South Carolina Federation of Chapters of the National Association of Retired Federal Employees (NARFE) which has some 24,000 Civil Service annuitants in this State. The President of their statewide organization, Mr Earle K. Rambo, will speak to you later today. Our legislative objectives are the same, and we feel confident that our proposal, when it becomes known to the thousands of other senior citizens throughout the state who are receiving pensions, will receive additional and unqualified support. These pensioners with their family members comprise a total of well over 120,000 South Carolinians.

By way of background, there were 34,182 retired members of the Department of Defense in South Carolina as of September 30, 1982. In addition, other members of the Uniformed Services, namely Coast Guard, NOOA, and US Public Health Service, and the 1,783

Survivors of DoD retirees in South Carolina (annuitants under RSFPP and SBP) should be considered in the retired military-related population. Average retired pay for DoD retirees as of September 30, 1982 was $10,808, with enlisted retired pay being $8,590 and Survivors' average annuity being $5,097. Mr Rambo will provide similar information on NARFE annuitants.

To State our proposal very briefly and to the point, we feel that there is a gross inequity in the State income tax laws that divide our pensioned senior citizens into two unequal groups, and that this inequity should be corrected. Specifically, all retirees from the South Carolina Retirement System (some 25,000 and increasing) are exempted from paying state income taxes on their pension income, whereas pensioners from Civil Service, the Uniformed Services of the United States, and other pensioners are required to pay state income taxes on their pension income. This means that state, county, and municipal employees, including teachers, policemen, firefighters, judges, and even legislators are exempted from paying state income taxes on their South Caroline Retirement System pensions while those drawing private and federal pensions and annuities are not. It is simply an issue of fairness to treat all pensioners in a like manner. An analogy would be for the federal government to excuse federal retirees from payment of federal income taxes on federal pension and annuity income, but to require it from other pension groups, including state retirees. I think you would agree that such a practice would not be tolerated. Nor do we think the current practice in South Carolina should be continued. As a matter of information, this same inequity was recently corrected in another state and won high praise for its sponsors and the legislature in editorial comment across the state.

The unfairness and incongruity of the current income taxation law is demonstrated by the fact that many so-called 'state, county and municipal jobs' are actually paid by federal funds in whole or in part. Also, credits are allowed for Military Service and Out-of-State Service to add to the credits of those participating in the South Carolina Retirement System, thus creating a very thin line between those who get the tax break and those who do not. And, under Code 12-7-565, 1976, the State has been allowed to

enter into reciprocal agreements with other states to refrain from taxing retirement income. Under this authority, reciprocal agreements have been consummated with 19 other states and although the agreements vary by state, most provide that participants in a given state's retirement system, upon relocation to South Carolina, are excused from paying state income taxes in South Carolina on their retirement income, in exchange for the same privilege for a South Carolinian moving to that state. Thus when a North Carolina school teacher, for example, retires here, he or she does not pay income tax on retired pay. This is a further example of discrimination against the groups for which I am speaking. Is that school teacher entitled to a tax break, whereas a Serviceman or Civil Servant who has spent perhaps three decades in the service of his country is not? We think not.

Current income tax law in South Carolina, aside from the total exemption of pension income of participants in the South Carolina Retirement System, provides for the following exemptions: Federal Civil Service; Armed Forces Retirement; and Certain Retired Persons, Age 65 and Over...deduct $1,200. We believe thatthis amount should be revised upward and the current tax law amended for several reasons in addition to the basic "fairness" issue we have raised, including: (1) The $1,200 exemption has been in effect for a number of years and has not been adjusted for inflation, (2) Senior citizens living on fixed pension incomes have need of financial assistance, (3) In the case of military retirees, we note that 37 of the 50 states, and all of the Southeastern states, offer a better state income tax situation than does South Carolina, (4) Certain age and length of service stipulations should be reexamined to insure equal treatment, and (5) Survivors of the three categories of pensioners noted above do not enjoy equal benefits under the law and this also should be corrected. Mr Rambo will present additional testimony.

The retirement programs and benefits of the State, Civil Service, Military and the many industry and private pension and annuity entities defy exact comparison. The criteria for retirement by length of service and/or age, medical benefits on retirement, benefits to survivors, and a wide range of income and other considerations,

make it difficult to establish a formula for equity between retirees from the South Carolina Retirement System and others that would not be faulted by some.

However, we feel that by working closely with a sponsor or sponsors in the General Assembly, we can arrive at a modification to the Tax Code that will do justice to all concerned parties and with an acceptable fiscal impact. Basically, we will seek changes that will provide other pensioners with essentially the same tax situation as is enjoyed by those who have participated in a full career under the South Carolina Retirement System. We expect that we can have a bill filed on behalf of our proposal in the early days of the 1984 Session of the General Assembly, followed by a legislative lobbying effort through the constituent members of our several organizations. We would welcome and deeply appreciate the support and endorsement of your Committee to help end the discriminatory practice of having two kinds of citizens drawing pensions in South Carolina. Thank you.

Byron E. Long

BYRON E. LONG
Colonel, USAF Retired
President

29 Hunters Forest Drive
Charleston, SC 29407
Phone (803) 556-1805

Mr. Earl K. Rambo, President
S. C. Federation of Chapters
National Association of Retired Federal Employees

This Association has about 24,000 retirees and survivors of retirees who draw an annuity in South Carolina. In addition, there are a large number of spouses and other dependents depending on income of these 24,000 members.

Mr. Rambo's testimony addressed the same problem which was discussed by the preceding speaker, Colonel Long; i. e., the inequities in the South Carolina Income Tax Code. He, too, asked the Committee for their support in amending the existing Code.

He gave the following examples which show that other Southern states have more liberal tax laws applicable to NARFE annuities: Texas, Tennesse and Florida - no state income tax; Florida - all civil service annuity tax exempt; Maryland - $7,500 tax exempt; Virginia - $7,200 at age 62 and $9,035 at age 65; Louisiana - $6,500 at age 65; Mississippi - $5,000 plus $1,500 additional at age 65; Georgia - $2,000, possibly all in 1984; and South Carolina - $1,200.

The average Federal retiree in South Carolina receives an annuity of $10,000 to $11,000 per year. Survivors rarely receive more than 55 percent of the amount received by the deceased retiree. Federal retirees receive no Social Security benefits and, therefore, pay South Carolina income tax on all their income, except the $1,200 tax exempt.

He asked the Committee for their help in getting the South Carolina Income Tax Code amended to extend to Federal Government and Military retirees and other annuitants the right to a tax exempt amount in line with what the average State employee enjoys on his/her State annuity.

Representative Waldrop wanted to know what dollar amount he had in mind for this tax exemption.

Mr. Rambo replied that they will take "whatever we can get."

SOUTH CAROLINA FEDERATION OF CHAPTERS

NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES

Presentation to Study Committee on Aging

September 23, 1983

by Earle K. Rambo

Mr. Chairman and Members of the Commission

Ladies and Gentlemen:

First, let me thank you for giving me an opportunity to appear before you today - to give you information on the organization I represent, what it does and what it hopes to help do for older South Carolinians.

No doubt you have questions such as:

1. Who am I?

2. Why am I here?

3. What does the organization I represent do for older South Carolinians?

4. What do we hope to do in the near future?

1st. My name is Earle K. Rambo, a native of Ninety Six, S. C., a life member of the American Society of Agricultural Engineers who has had experience as a college professor, a State Extension Agricultural Engineering group leader, and twenty-three years of foreign service for the Department of State, Agency for International Development and preceding organizations giving technical assistance to developing countries. Service periods ranged from two years in India, five years in Lebanon, seven years in Panama, seven years in Laos, two years in Nigeria and temporary assignments in fifteen or more other countries. I returned to South Carolina to retire in 1972 with over thirty-two years of Civil Service credit.

If there was ever any question in my mind as to what state I would retire in, it was probably settled in early October, 1966, when I received at my office in Vientiane, Laos, a

letter dated September 30, 1966, from Mr. John G. Smith, Chairman, South Carolina Homecoming Committee, which stated in part:

"Dear Mr. Rambo:

We would like to invite you to be one of our honored guests at the South Carolina Homecoming here on Hilton Head Island, November 18 through November 22. This will be a unique event honoring native South Carolinians who have distinguished themselves in various fields and who no longer reside within the State. Nationally recognized Carolinians who are leaders in church, military, business, finance, arts, science, and government fields are being invited."

The 1966 flood in Laos by the Mekong River, tenth largest river in the world, made it impractical for me to consider accepting that wonderful invitation. Of the many honors I received for my work in the U. S. and abroad, I still cherish that invitation from South Carolina and returned here to live after residing elsewhere for over 36 years.

2nd. I am here today as President of the South Carolina Federation of Chapters of the National Association of Retired Federal Employees. We have about 24,000 retirees and survivors of retirees who draw an annuity in South Carolina. There are also a large number of spouses and other dependents depending on income of the 24,000. I represent that entire group and others as I speak to you today.

3rd. There are eighteen chapters of the National Association of Retired Federal Employees in South Carolina. These chapters are located in:

Columbia	Aiken
Florence	Greenwood
Sumter	Anderson
Myrtle Beach	Clemson
Charleston	Greenville
Pawley's Island	Spartanburg
North Charleston	Rock Hill
Summerville	Orangeburg
Beaufort	Newberry

We have a state Field Officer for each of the six congressional districts and they are now studying the feasibility of organizing additional chapters in the state.

3rd. NARFE chapters meet from six to eleven times a year bringing retired persons together. Some chapters have luncheon meetings, some dinner meetings, some "pot luck" or covered dish luncheons. These meetings serve as an "Eating-Out Time" and as a social get-together. Most chapters have outside speakers on subjects of interest to their members, such as:

Artificial Joints - How they work and problems encountered.

Artificial Respiration

Wills, Trusts and Endowments

State & Federal Income Tax Forms.

Speakers for the meetings are arranged for by the Program Chairman.

Sunshine Committe members keep in touch with the sick and bereaved families of members.

Public Relations Officers keep our members informed on meetings and special happenings.

Service Officers are available with necessary forms when needed by survivors in the case of death of a retiree. They also help with income tax problems and other personal problems. They work hand-in-hand with the Sunshine Committee members. NARFE is truly a service organization for its members.

4th. We are always looking for ways we can increase our service to our members; however, we are not selfish and today NARFE in South Carolina is joining with the South Carolina Council of chapters of the Retired Officers Association to point out some inequities in the South Carolina Income Tax Code and ask your support in helping get the code ammended.

Other southern states have more liberal tax laws applicable to NARFE annuity. Examples of exemptions are:

Texas - No state income tax
Tennessee - No state income tax
Florida - No state income tax
Alabama - All civil service annuity tax exempt
Maryland - $7,500 tax exempt
Virginia - $7,200 at age 62, $9,035 at age 65

Louisiana - $6,500 at age 65
Mississippi - $5,000 plus $1,500 additional at 65.
Georgia - $2,000 with hopes of all in 1984
South Carolina - $1,200

The average federal retiree in South Carolina receives an annuity of $10,000 to $11,000 per year. Survivors receive much less, never more than 55% of that received by the deceased retiree. We retires who have had a long period of service receive no Social Security benefits; therefore, we pay South Carolina income tax on all except $1,200.

As of June 1982, 234,920 receipients of Social Security received an average of $4,531.20, all exempt from state income tax.

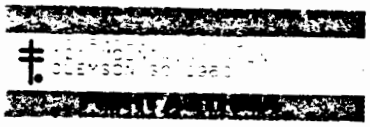
I am told that South Carolina State employees pay no state income tax on state retirement and many of these also draw, tax exempt, Social Security.

We solicit your support in getting an ammendment to the South Carolina Income Tax Code which would extend across the board to Federal Government and Military retirees and to other retirees of retirement age who draw an annuity, the right to subtract not $1,200 but an amount in line with what the average state employee enjoys on his or her state annuity. As you can see, we are not being selfish in our request but are asking that it be extended to others, not just to retired federal and military groups.

Today South Carolina ranks high among the states as a good place to retire. Let's add another plus with an ammendment to the Income Tax Code.

Once again I thank you for the opportunity to appear before you today.

Earle K. Rambo, President



Mrs. Gail Reyes, President
S. C. Association of Council on Aging Directors
Barnwell, SC

This Association is an organization of executive directors of county organizations on aging. One of their purposes is to serve as an advocate for Councils on Aging and the clients they serve. Their effort is directed toward providing a coordinated service system for the aging and, thereby, delay admission into a nursing home.

Her testimony addressed primarily the necessity of passage of House Bill, H-2364, which would provide funds for services such as home-delivered meals, health maintenance, day care, etc. Although 90 percent of the persons served must be 60 years and older, the bill provides that 10 percent of those served may be in the 55-59 age range. Persons in this age category may not be eligible for assistance under the Older Americans Act unless a spouse is 60 years or older. Many times persons in this age group experience, what Mrs. Reyes called, "fall-out." In addition, H-2364 does not require that a recipient is eligible for nursing home care.

Other aspects of the Bill are:

1. It is not limited to persons in financial need; it requires fees based on a sliding scale. Funds received this way will be used to expand services.

2. No new administrative layer is needed. The funds appropriated under this legislation would be dispensed by the State Commission on Aging and the Area Agencies on Aging.

3. Assessment and service plans must be done before services are provided. This assures that the most needy receive the limited services available.

4. Better coordination and utilization of available services by the Councils on Aging for the benefit of older South Carolinians.

SOUTH CAROLINA ASSOCIATION OF COUNCIL ON AGING DIRECTORS

The South Carolina Association of Council on Aging Directors is an organization for Executive Directors of county organizations on aging. One purpose of that organization is to serve as an advocate for Councils on Aging and the clients they serve. As president of the association, I am here to urge passage of House Bill #2364 sponsored by Representatives Harris, Blackwell and Waldrop. The legislation was developed by a South Carolina Commission on Aging task force made up of a variety of citizens, agency and organization representatives.

The Aging Network in South Carolina has long provided community based long term care services for South Carolina's older citizens in an effort to address the issue of premature institutionalization. Our focus is on providing a co-ordinated service system that helps older people function independently for as long as possible. When I think of our purpose, I think about the word prevention. You may think that a strange word. We certainly cannot prevent the aging process, but we hope we can prevent or at least delay an older persons admission to a Nursing Home. You see, the aging programs provided long term care services long before the phrase became such a popular one.

This line of thinking is the very core of House Bill 2364. This bill would provide funds for services such as home delivered meals, health maintenance, day care, and others. Although 90% of the persons served must be 60 and older, the bill provides that 10% of those served may be 55 through 59 years old. I believe this is especially commendable since persons in this age category may not be eligible for assistance under the Older Americans Act unless a spouse is 60 or older and Social Services Block grant funds cannot be stretched to meet all the needs. Many times this age group experiences "fall-out".

In addition, this legislation would not require that a recipient be eligible for Nursing Home care. Many older people need at-home-services, but may not qualify for intermediate or skilled services. Perhaps the availability of these funds could help prevent an older person from reaching the point of needing Nursing Home care. They would certainly delay the need for it.

Another aspect of this legislation is that it is not limited to persons in financial need. This should make the tax payer much more supportive of the expenditure of these funds. Too often we hear the complaints, and they are legitimate, that if one works hard all his life and supports the government, he finds no government assistance when he needs it. The individual who finds himself just over the medicaid income limit for instance is much worse off financially than is the person who meets the eligibility standards with less income. Perhaps a person in need of community based long term care services can afford to pay a part of the cost, but does not have sufficient income to pay the total cost. House Bill 2364 addresses this since it requires fees based on a sliding scale. The funds received will be used to expand services. The Aging Network has proven this concept works with its nutrition and other services, even though our contributions are voluntary while this bill requires fee collection.

The funds appropriated under House Bill 2364, would be dispensed through the State Commission on Aging and the Area Agencies on Aging. This would not require the addition of another administrative layer or create a so called "non-agency" to oversee the program. Area Agencies (or Regional Offices) are already in place. The agencies have experience and expertise in evaluating and monitoring services being provided as well as completing needs assessment and doing planning and program development for services in their regions. The availability of this established network allows more funds to reach the provider level so that more services reach the person in need.

House Bill 2364 requires that assessment and service plans be done before services are provided. This procedure is being used by most Councils on Aging in the State in order to assure that the most needy receive the limited services available. Prior experience in and continued emphasis on service assessment and case management in the Aging Network will help assure that the frail elderly are given preference for #2364 services.

Additionally, the Councils on Aging have demonstrated their ability to provide the 2364 services by their previous experience in community based services. In addition to serving as assessors and managers of services for older people, Councils on Aging also provide the services themselves. This ability serves to better co-ordinate and utilize available services for the benefit of older South Carolinians.

The South Carolina Commission on Aging could have requested an additional 2.5 million for these services as part of its budget. However, the general feeling is that the State of South Carolina needs to be one of the front runners in establishing legislation which addresses the need for community services for older persons. Over the past ten years South Carolina has seen a 46% increase in the population age 60 and older. This trend is expected to continue with South Carolina rating second only to Florida as a retirement state.

The South Carolina Aging Network has for many years provided the core for community based long term care services. We are continually striving to improve the quality of those services and reach more and more of our older Americans in need. House Bill 2364 can go a long way in helping us meet the needs of those currently being under-served and those not being served at all.

The South Carolina Association of Council or Aging Directors strongly urges passage of House Bill 2364.

Gail C. Ruyes

Ms. Loretta Brown, Chairperson
Regional Aging Advisory Committee
Central Midlands Area Agency on Aging
Columbia, SC

This Area Agency serves Fairfield, Lexington, Newberry and Richland Counties. With the continued support of the county agencies which actually deliver the services to the elderly, many new projects are being planned or implemented. Some of these are:

1. Development of a regional computerized client information system, funded by a grant from the Robert Wood Johnson Foundation. This system encourages coordination of agencies serving the same clients. Duplication of services are thereby avoided.

2. A uniform regional case management system is currently set up by five of their component agencies.

3. The Well Elderly Clinic concept is continuing to demonstrate the benefits of preventive medicine for older persons.

4. Homemaker services to the elderly will be increased this year through funding from the State's Medicaid waiver AFDC Homemaker/Home Health Aide Project.

5. This Agency's idea for an elderly-administered central kitchen has been accepted by DSS and the Joint Appropriations Review Committee. This central kitchen would provide at least 1,000 meals per day to the elderly, if they can secure the budgeted funds for this project. An estimated 180 additional meals could be served daily through cost-savings efforts of this nonprofit corporation kitchen.

Central Midlands Regional Aging Advisory Committee asks for support of the following issues:

1. Tax incentives to family members who care for and keep the elderly at home.

2. Rental subsidies for elderly renters.

3. Medical assistance to elderly persons who do not have Medicare, Medicaid, or individual health insurance.

4. Passage of House Bill H-2364 which will provide many needed services to the elderly in the community.

Dr. Holler asked if they have given any thought or study to the question of transportation for the elderly.

Ms. Brown explained that this problem in their agency is being handled by a Transportation Advisory. They are providing some transportation to the recipients or clients that they are already serving through their contractor or component agencies. When they plan for services, they plan as well as they can for the transportation.

Dr. Parrish asked for a more detailed description of the elderly-administered central kitchen.

Ms. Brown replied that this will be established as a nonprofit corporation. It is set up as a demonstration project whereby it would provide employment for the elderly as well as meals. If this project is in fact completed, they would be able to bid on a catering contract that now exists at Central Midlands or that many of the several planning areas in the State have. A central kitchen would provide employment for older citizens, serve meals to a greater number of elderly, and reduce the financial base for operation and, therefore, reduce the cost they would have to pay to a caterer during a fiscal year. This is in an experimental stage now and they are bidding for a contract for it to be a demonstration project in their region.

TESTIMONY
PRESENTED TO
THE STATE OF SOUTH CAROLINA
STUDY COMMITTEE ON AGING
BY
LORETTA BROWN
CHAIRPERSON
CENTRAL MIDLANDS REGIONAL PLANNING COUNCIL'S
REGIONAL AGING ADVISORY COMMITTEE

SEPTEMBER 23, 1983

Today I am representing one of the state's regional Area Agencies on Aging. I am presently serving my second term as Chairperson of the Central Midlands' Regional Aging Advisory Committee.

The Central Midlands' Area Agency continues to plan, develop, coordinate, and fund services and programs for the elderly of our region, so that older individuals may enjoy a higher quality of life.

We are concerned not only with the 5% of the elderly population which are in the state's hospitals and nursing homes, but also with the remaining 95%. These non-institutional elderly range from being completely independent and desiring only recreational activities and the opportunity to volunteer to help others, to those more unfortunate, who are health impaired and homebound and in jeopardy of institutionalization.

Our Area Agency on Aging serves Fairfield, Lexington, Newberry and Richland Counties. With the continued support of the county agencies which actually deliver the services to the elderly, many new projects are being planned or implemented. I want to mention a few of these.

1. With Robert Wood Johnson Foundation funding, a regional computerized client information system has been developed and client information is presently available to participating social service agencies. This system encourages the coordination of agencies who serve the same clients; thus avoiding duplication of services, and reducing the number of times an older person needs to answer the same questions.

2. A uniform regional case management system is currently being implemented by five of our component agencies. Thus we are looking at the total needs of an elderly client, and services are planned, provided and coordinated with other local agencies.

3. Several years ago we spoke to you on the concept of a Well Elderly Clinic. This year, through a variety of funding sources, we will demonstrate the benefits of preventive medicine for older individuals. Physical examinations, on an appointment basis, will be available on a contribution basis for individuals over 60 who have not had a physical for many years.

4. Our homemaker services to the elderly will be dramatically increased this year through funding from the State's medicaid waiver AFDC Homemaker/Home Health Aide Project. This national demonstration project will provide training and employment to AFDC recipient mothers, while they provide homemaker services to those elderly who are health impaired, disabled, and homebound. In some cases, the project will be able to expand services to persons already receiving homemaker and home health aide services.

5. Our agency's idea for an elderly-administered central kitchen has been accepted by the Department of Social Services and the Joint Appropriations Review Committee. The central kitchen would provide at least 1000 meals to the elderly per day. If we can now secure the budgeted funds for this project, this region will not only be able to employ older individuals in this operation, but, through the cost-savings efforts of the non-profit corporation kitchen, an estimated 180 additonal meals will be served daily to the elderly.

Although we continue to develop new programs and expand much needed services, there are many other issues and needs which must be addressed.

The aging network (which includes the State Commission on Aging, the Area Agencies on Aging, and local service providers) needs your support in two areas: 1) to provide a wide range of services to older South Carolinians, and 2) to plan for the future. Fifty years from now when the South Carolina 60+ population has doubled, we must be ready to provide an increased number of quality nursing home beds, and a greater number of community-based services for those older individuals who can and who choose to remain independently in their own homes.

Therefore, the Central Midlands Regional Aging Advisory Committee asks your consideration and support of the following issues.

1. Tax incentives shall be awarded to family members who care for and keep the elderly at home.

2. Elderly renters, as well as homeowners, need subsidies. Rental subsidies might be approached in either of two ways.
   (1) directly to the elderly tenant, or
   (2) to the landlord who is willing to lease adequate and tenantable housing to persons 60 years old and older.

3. Medical assistance to elderly persons with neither medicare, medicaid, nor individual health insurance should be appropriated, either as,
   (1) a supplemental aid, or
   (2) primary health/medical care assistance.

4. Budgetary consideration must be given to the provision of community services and in-home care for the elderly as an alternative to institutional care; subsequently, reducing the overall public financial burden and increasing the sense of independence and self-worth by each older South Carolinian. We, therefore, request your support and passage of House Bill #2364, which will provide much needed services to the elderly through the existing aging network.

I thank you for the opportunity to share with you today our many activities and also our concerns.

LCB/ha
9/23/83

Ms. Yvonne Simpson, Aging Unit Director
Appalachian Council of Governments
Greenville, SC

This Agency services Anderson, Cherokee, Greenville, Oconee, Pickens and Spartanburg Counties. As an Area Agency they allocate Federal and State dollars necessary for needed services to the elderly in these counties. Ms. Simpson asked the Committee to consider the following concerns:

1. Support of House Bill H-2364.
2. Continuation of Adult Day Care, which costs about $8 per person per day and enables older people to live with working relatives.
3. Life-line telephone discounts for the elderly.

REMARKS OF: Mrs. Yvonne S. Simpson before the State Study Committee on Aging

My name is Yvonne Simpson. I am the Aging Unit Director of the Appalachian Area Agency on Aging of the Appalachian Council of Governments. We serve Anderson, Cherokee, Greenville, Oconee, Pickens, and Spartanburg Counties. As an area agency, we allocate federal and state dollars necessary for providing needed services to the elderly in Anderson, Cherokee, Greenville, Oconee, Pickens and Spartanburg Counties. We also remain abreast of what is being done in these counties and on continuing needs of older people in the upstate area. I want to share with you the concerns of members of our Aging Advisory Committee and service providers, and to ask you to consider these concerns as you develop your legislative priorities for the upcoming year.

1. Community Services Legislation through the State Commission on Aging and Area Agencies on Aging - We support this vital piece of legislation which calls for statewide funding of services to assist older people to stay in their own homes and out of nursing homes and other institutions for as long as possible. We have a solid aging network made up of aging providers, area agencies and the state agency. We call on the study committee to use this network in allocating these state dollars.

2. Continuation of Adult Day Care - The Area Agency is increasingly concerned about those services that can best be used to keep people in the community and away from inappropriate placement in institutions. In our region, we have seen day care services for adults as an

effective and inexpensive way to prevent inappropriate placement in nursing homes. In adult day care, frail older people who live with working relatives are provided assistance during working hours in taking medication, getting nutritious meals and in getting outside socialization. Day care costs are estimated at approximately $8.00 per person per day. We are concerned that day care for adults is not viewed as a priority by the funders under the Social Services Block Grant. We ask the committee's concern and enthusiastic support in making adult day care services a priority in this state. Adult day care is a community service that helps older people live with their families. No other alternatives exists for family members who both need to work and who want to care for their older relatives. We must give families the support that they need to keep relatives in their homes.

3. One final recommendation is that which is on the minds of many many senior citizens, "how long can I afford a telephone"? Everywhere in the aging program older people have expressed concerns. Ladies and gentlemen, a telephone is a necessary for many seniors. It is that link between the older community and that older person who must live alone. The telephone provides access to police protection, medical help, socialization and other services that that older person might need. It therefore concerns us that basic telephone charges are expected to double as a result of the ATT break-up. We call on the Legislative Study Committee to vigorously sponsor and garner support for life-line telephone discounts for the elderly. It can be done. To do less would be to jeopardize the well-being of countless older South Carolineans.

In closing, may I again express appreciation for the opportunity to speak before you today. As you develop priorities, I do hope you will heed and accept the recommendations of the Appalachian Council of Governments as the Area Agency. If we can provide you with any further clarification, please let me know and I would be happy to do so.

Again, thank you very much.

Mrs. Pauline Wheeler
2220 Clark Street
Columbia, SC 29201

Mrs. Wheeler's statement addressed the need for home care services, the 1982 property assessment, and asked for the difference between the Council on Aging Home Care Service and Medical Personnel Pool Service.

Senator Rubin commented that the property assessment had been of great concern last year. Legislation was introduced on the House side asking for an increase in the sales tax with about half of the amount going to Homestead Tax relief. The subject is stillvery much alive; however, at the present time the proposal on the 1 percent sales tax increase seems to veer toward the usage for education. "I hope the citizens will fight the battle of property tax relief."

On the other matters discussed, he told Mrs. Wheeler that staff will research these.

14 September 1983

Legislative Study Committee on Aging
Columbia,
South Carolina, 29202

To Whom it May Concern:

I am interested in Home Care Service , for a few hours daily, after a senior citizen has been dismissed from the hospital, until that person is able to help themselves, for the following reasons:

1. Some cannot afford a Nursing Home.

2. If an elderly citizen should like to spend their last days at home and doesn't have adequate help, what measures can be taken to facilitate their wants?

3. The council on aging in Anderson County only allows a nurse to visit , a totally helpless person, two or three times a week. Under certain circumstances, could their visits be extended?

4. What is the difference between the Council on Aging Home Care Service and Medical Personnel Pool Service? What are the requirements of each?

5. The 1982 assessment of property, in many instances increased 300% and 400%, which has brought handship on our senior citizens, because they are on fixed income. This matter should be looked into.

Sincerely Yours,

Mrs. P. Wheeler

Mrs. P. Wheeler
1220 Clark Street
Columbia, South Carolina 29201

Dr. Gerald L. Euster, Professor
College of Social Work
University of South Carolina
Columbia, SC

Mrs. Amy Pace, Graduate Asst.
College of Social Work
University of South Carolina
Columbia, SC

This testimony stressed the importance of voluntary social welfare programs and volunteer services and showed the value of volunteer efforts.

On August 16, 1983 Governor Riley signed executive order 83-40, creating the South Carolina Division of Volunteer Services under the auspices of his own office. Thus, South Carolina joins 32 other states which have offices to implement volunteer services and serve as clearinghouses for information regarding the volunteer recruitment.

The University of South Carolina, College of Social Work, was awarded a Federal grant in October of 1982 to train gerontology students and State Agency personnel for leadership and participation in the volunteer movement in behalf of the growing elderly population. The College of Social Work has developed the first graduate level course in the country pertaining to "Volunteerism with the Elderly." However, volunteers still remain a vast untapped resource.

To insure the survival and continuing growth of volunteerism with the elderly, Mrs. Pace suggested the following steps:

1. Agencies in the aging network should commit staff to planning, training and supervision required to maintain quality volunteer programs.

2. Policies regarding insurance for volunteers, reimbursement for travel and other out-of-pocket expenses should be clarified from an official perspective.

3. The Governor's Division of Volunteer Services will shortly publish guidelines and standards regarding volunteerism. All aging agencies involved in volunteer programs should adhere to these.

4. South Carolina aging agencies should seek the involvement in the volunteer movement from the corporate sector.

5. The wealth of potential volunteers to serve the elderly should by tapped by churches and synagogues.

6. Exchange expertise, ideas and information among communities.

VOLUNTEERISM WITH THE ELDERLY: MILES TO GO BEFORE WE REST

To: The Honorable Senator Hyman Rubin and Distinguished Members of the South Carolina Joint Legislative Study Committee on Aging

Thank you for providing us the opportunity to present testimony before this Committee.

Voluntary social welfare programs and volunteer services are at the heart of our democratic process. They are part of our American heritage, serving as concrete expressions of our individual and group creativity, healthy altruistic motives, social responsibility, and commitment to community goal setting and problem solving. The spirit of volunteerism dramatically reflects our growing concerns about the "centralization" of power and decision making in government. It is particularly imperative that we encourage citizens to participate in planning solutions to problems and needs that affect them, their families, and neighbors.

In a more pragmatic sense, volunteers may serve to reduce stress and pressure on overburdened professional staff in human service agencies, provide a constructive, nonthreatening support system for clients, often generate innovative ideas and diagnostic insights about agency programming, and help stretch limited funding resources. Volunteers can help make programs more open, visible and subject to public review and support. Social welfare history reminds us that many of our most successful and effective human service programs have been the direct outcome of nonprofessional citizen involvement.

It is extremely significant that on August 16, 1983 Governor Riley signed executive order 83-40, creating the South Carolina Division of Volunteer Services under the auspices of his own office. The Division

will act as an agent for planned positive change in the structure and use of volunteers in the public sector, serving both as a facilitator and stimulator for volunteerism and various forms of citizen involvement. Our state joins a list of thirty two other states which have organized offices to implement volunteer initiatives and serve as clearinghouses for information regarding volunteer management, training, recruitment, and recognition. Governor Riley is to be commended for his sincerity in advocating for expanded volunteerism within our state agencies.

We are fortunate in South Carolina that much of the foundation for volunteer program development, training, and education has been established. The University of South Carolina, College of Social Work, was awarded a significant grant from the United States Administration on Aging in October 1982 to train gerontology students and state agency personnel for increased leadership and participation in the American volunteer movement in behalf of our growing elderly population. The grant project has emphasized a substantial partnership between the University and our state's aging agencies through establishment of various training and consultation structures.

The College of Social Work has developed the first graduate level course in the United States pertaining to "Volunteerism with the Elderly." This Committee can be assured that both graduate and undergraduate students will receive quality instruction on such topics as history and trends, volunteer motivational dynamics, program development, training and management issues, and professional-nonprofessional collaboration. Through this and other courses offered to students in all the helping professions, volunteerism will be stressed as a basic component of all agency

programming. Retired students desiring to enroll for either university credit or to pursue continuing education will be encouraged to participate in volunteerism courses.

South Carolina is indeed blessed with some exceptionally talented persons who have created outstanding volunteer programs and projects to serve our state's elderly. Project LOVE (Let Older Volunteers Educate), RSVP, Foster Grandparents, Senior Companions, Senior Hotlines, and numerous church sponsored respite care programs have emerged in response to the various needs of elders and their families throughout our communities. Volunteers assist the elderly in hospitals, nursing homes, home health care, personal care, homemaker services, home-delivered meals, transportation, and many other areas. Many well functioning elders provide a wide array of volunteer services to others in their age cohort in both institutional and community based long term care. Retired active South Carolinians provide an immense resource for colleges and universities, libraries, museums, school systems, public and private agency advisory councils, and other areas where community service and volunteerism are required. The vitality, commitment and expertise of elderly volunteers are well documented in our growing literature.

Despite our tremendous growth in awareness of the potential values of volunteers service, there is obvious unevenness throughout our agencies in volunteer programming, management skills, supervision, training, and recognition of contributions. Volunteer programs and services usually exist at least "on paper", but often struggle for survival in senior centers, nutrition sites, and community agencies. Some agencies are able to recruit talented and motivated volunteers of all ages, while others are befuddled

and frustrated by lack of community involvement and contribution of necessary resources. Where the "chemistry" is right, volunteers and professionals work cooperatively in agencies to benefit the elderly. In other agencies, volunteers are tolerated in their efforts but often discontinue their service contributions prematurely when they feel under-utilized, under-supervised, and under-valued.

Despite the anticipated and unanticipated problems that occur in any organization utilizing volunteers I am sure that we would all agree that volunteers remain a vast untapped resource. They will not go away nor would we want them to go away even if we had adequate numbers of professional staff to serve our elderly in the aging network.

What, then, must be done to insure the survival and continuing growth of volunteerism with the elderly?

1. Since "volunteerism" is rapidly emerging as a cost-effective process and mechanism for better serving many elderly clients in the aging agency network, it is imperative that such agencies commit staff to planning, training, supervision, and other tasks required for the maintenance of quality volunteer programs. Professionally trained and/or qualified persons should be assigned responsibilities to direct, monitor, and evaluate the quality of voluntary action within human service agencies for the elderly.
2. All agencies serving the elderly with special volunteer programs should clearly state volunteer program goals, procedures, and responsibilities of persons involved. Policies pertaining to insurance for volunteers, reimbursement for travel and out-of-pocket expenses, workers' compensation, and other issues should be clarified from an official perspective.

3. All aging agencies utilizing volunteer programs and services as a means of helping elderly clients should adhere to and build upon the guidelines and standards for volunteerism in state government soon to be published by the Governor's Division of Volunteer Services. Aging agencies should design programs that are based upon sound recruitment policies, skillful interviewing and placement of volunteers, structured staff supervision, and deliberate attention to service recognition. Attention must be given to the right's of volunteers in such areas as appropriateness of job assignment, staff respect, policy and decision making, and career advancement within the organization.
4. South Carolina aging agencies should be encouraged to conceptualize strategies for mobilizing partnerships with socially responsive businesses and corporations. There is nationwide evidence that the corporate sector is often willing to assist human service agencies through such mechanisms as releasing employees to volunteer, loaning company personnel, special service projects for the elderly, providing money and materials, and establishing retiree community involvement programs and clearinghouses. The Honeywell Corporation, Levi-Strauss Company, and Bell Telephone, among others, have created models of corporate sector involvement.
5. Churches and synagogues should be especially reminded that through their respective congregations they possess a wealth of potential volunteers to serve the elderly. Men's, women's, and youth clubs have displayed enormous concern for the elderly in our communities

through home repair, weatherization, clean up, escort-transportation, and adopt-a-grandparent programs. Intergenerational volunteering structures are still in their infancy and will continue to evolve as youth feel greater connection to elders.

6. More traditional and effective volunteer programs should be encouraged in communities seeking ways to aggressively reach out to elderly citizens. The Commission on Aging can take an active leadership role by facilitating the exchange of personnel into underdeveloped communities to assist in establishing telephone reassurance, friendly visiting, senior companion, and emergency response programs. The expertise availabe in one community may well serve neighboring communities. Opportunities for volunteer program personnel to exchange ideas and information would greatly assist agencies toward more constructive programming to combat isolation and demoralization of our elderly citizens.

Prepared by:

Dr. Gerald L. Euster
Professor
University of South Carolina
College of Social Work

and

Mrs. Amy Pace
Graduate Assistant
University of South Carolina
College of Social Work

Mr. Fletcher Spigner, Executive Director
Council on Aging of the Midlands
Columbia, SC

The Council on Aging of the Midlands was formerly known as Richland-Lexington Council on Aging. This Council provides many services for the older people of Richland and Lexington Counties. One of the most significant services they render is case managment. Last year, in addition to making direct services to their clients, they made over 1,000 referrals to 89 different agencies, and 63 organizations made referrals to the Council. Mr. Spigner called this "coordination and cooperation personified."

Two very important in-home services they provide are 1) home-delivered meals and 2) homemaker services. Added to these services, they have the following: a congregate meal program, an employment service, a telephone reassurance service, transportation, a retired senior volunteer program, and they are the sponsor of many special events and activities for seniors and administer a senior center as well. Together with the Central Midlands Regional Planning Council they won concept approval of the State's first central food kitchen which, if established in this region, will serve about 181 more meals per day.

One of the issues Mr. Spigner believes in very strongly is the long term care issue. In funding the State's Long Term Care Project, he asked to make sure that the new system does not duplicate the existing system.

He further urged introduction of legislation to increase the State income tax deduction from 9 cents to 20 cents per mile for volunteer travel expenses.

He asked to adopt a State's Bill of Rights which would cover residents of nursing homes that do not accept Medicaid/Medicare. There are only two of these homes in South Carolina.

Representative Blackwell asked if the State would force the conditions of a State's Bill of Rights on private, not-for-profit and religious institutions that do not accept Medicaid/Medicare.

Mr. Spigner confirmed this.

On the tax allowance for volunteerism, Senator Rubin said that he had the role of carrying this through the Finance Committee. It was introduced at 18 cents, and he felt lucky to get 14 cents. The principal obstacle was not indifference but the fact that the Federal Government allowed only 9 cents.

Mr. Spigner stated that the Council on Volunteerism has recommended to the Governor to push for the 20 cents deduction.

PRESENTATION BEFORE THE STUDY COMMITTEE ON AGING

COUNCIL ON AGING OF THE MIDLANDS

Fletcher Spigner, Ex. Dir.

September 23, 1983

My name is Fletcher Spigner, and I'm the Executive Director of the Council on Aging of the Midlands, formerly Richland-Lexington Council on Aging.

I am not going to take a lot of your time today, but there are a few issues I would like to bring to your attention. But before I do that, I would, by way of introduction, like to introduce you to the Council on Aging.

The Council on Aging of the Midlands provides quite a number of services to the older people of Richland and Lexington Counties. One of the most significant things that we do is something that you have heard about over and over again today, and that is Case Management. We have been providing Case Management services for over ten years and are in the process of developing an even more sophisticated system in order to serve the needs of older people better. The point I wish to make here is that we have done a pretty darn good job over the years of assessing clients' needs and getting them services, in order to keep them in their own homes and in their own communities and out of institutions. Last year, for example, the Council on Aging of the Midlands provided direct services to our clients as well as made over 1,000 referrals to 89 different agencies within in the Columbia area. This is coordination and cooperation personified. Sixty-three organizations made referrals to us. I don't mind saying that the Council on Aging of the Midlands has become the source and resource of professionals in our community who are dedicated to serving older people.

As I have indicated, the Council on Aging does provide direct services, and most of the referrals of our Case Management staff are made internally to the various programs that might help older people live longer and happier in their own homes. Notably, we provide a couple of very important in-home services: home delivered meals and homemaker services. To say the least, our home delivered meals program

is a model for the State, and it has been recognized as such on a number of occasions by the funding source. Our homemaker program is rather small but darn good, and we anticipate expanding this service a great deal in the next 30 days. If and when either of these services is expanded, it is entirely appropriate that they be expanded where they exist now, and that is with the Council on Aging of the Midlands. Our experience, both in direct service delivery and in service systems' applications, should not be overlooked as we, both Government and private sectors, expand services to older people in the future.

In addition to these very visible in-home services that we provide, we conduct a congregate meal program, an employment service, a telephone reassurance service, a transportation, a retired senior volunteer program, and we are the sponsor of numerous special events and activities for older people and administer a senior center as well. A couple of years ago we took a risk and pursued HUD, Section 202 funding and won. The result: one of the Nation's most beautiful and most functional housing developments for older people. This year we took a risk again, except this time we were joined on the limb by Central Midlands Regional Planning Council, and we won. The result: Concept approval of the State's first central food kitchen which, if established in this region, would mean approximately 181 more meals per day.

I think one of the issues related to the cooperation and coordination among those of us who serve older people is the long-term care issue. I believe very strongly in long-term care; within limited resources we have been doing it for over ten years. One of the things that I want to emphasize is that direct services ought to be expanded where they are now. In our case, as I have emphasized, We have both the expertise and experience to give you a first rate job, and we are always striving to do a better job by becoming more sophisticated, more professional, more knowledgible, and the like. In funding the State's long-term care project, which I basically have no problem with, it seems to me, however,

that the only responsible way to go about it is to make sure that the new system does not duplicate the existing system. It ought to be the case of the State's supplementing the existing pool of expertise and experience so that older people can be served better.

Another issue comes in view of budget cuts and the increased need for volunteers. I urge you to introduce legislation to increase the State Income tax deduction from 9¢ to 20¢ per mile for travel expenses incurred in the performance of volunteer duties. This was recommended to the Governor by his Council on Voluntarism and is again being discussed in the U.S. Congress. If we truly value the work of volunteers in South Carolina and are serious about expanding their services to our communities, we must invest in support systems and tax incentives to help them. Not only will this help older people who are served by volunteers through our agencies, but it will help older people themselves who, on fixed incomes, need all the help that they can get to do meaningful volunteer work.

South Carolina would be among a very few States if we were to pass such legislation. This is one place where South Carolina can lead the Nation.

There has been so much attention today on keeping folks out of institutions, and that is as it should be. However, there is a small group of older people in South Carolina who are not covered by what is known as the Federal "Patient's Bill of Rights." This document only covers the residents of nursing homes accepting Medicare/Medicaid patients. It is but a small problem when you take the world view, but when you take the view of a patient in a nursing home that does not accept Medicare/Medicaid patients, we must show empathy, and we can very easily by adopting a State's Bill of Rights which would cover these vulnarable residents.

Ms. Alberta Rowe, Commissioner
S. C. Comission on Women
Columbia, SC

During the past year the issues of older women have become the Commission's major concern. Worldwide, aging women outnumber aging men two to one. In this State, women make up 61.3 percent of the State population of 65 years of age or older. Fifty-five percent of these live alone and have limited choice of services, mobility and opportunity to voice their concerns.

The Commission asked the Committee to focus their attention on only four of the problems of elderly women: safety, health, financial security and quality of life.

Ms. Rowe called attention to their project called the Talent Bank which is a publication listing appointments of capable women to South Carolina Boards and Commissions, very similar to the handbook published by the Study Committee on Aging entitled South Carolina Boards and Commissions, Opportunities for Older Citizen Representation.

Dr. Parrish asked for a specific explanation as to item No. 1, safety. Does the request to the Study Committee mean to get information to crime watchers, sheriff's deputies, etc.

Ms. Rowe replied that she will refer his question to the Commission.

Dr. Parrish added that he wanted the question to be a matter of record and clearly defined so that the Committee can help implement the proposal.

SC COMMISSION ON WOMEN
Statement to Committee on Aging 9/23/83
Clelia D. Hendrix, Chairperson
Alberta Rowe, Commissioner & Presenter

You can tell from the name of the Commission that I represent that our chief constituency is women. My presentation will share some common concerns that we have with the Study Committee on Aging.

During the past year the issues of older women have become one of our major priorities. We have found that worldwide, aging women outnumber aging men two to one. In South Carolina, although women make up 51.5% of the total population, women make up 61.3% of the state's population of 65 years of age or older.

Because most men marry women younger than themselves and tend to die at an earlier age, women are often left widowed. Of the elderly women in S.C. 55% of them live alone. We have found that many of these women are vulnerable persons who have limited choice of services, limited mobility, and limited opportunity to voice their concerns. Some are incapacitated, some physically handicapped - and all of them live in fear.

The majority of S.C.'s elderly women have spent their lives in support roles, they draw small incomes, and were ill-equipped when widowed to find gainful employment. We have no statistics to show, but we are told that in Greenville County, which has the highest number of 60 years and above citizens living below the poverty level, that elderly women are the "poorest of the poor."

The Commission on Women would like to recommend to you a focus on the unique problems of elderly women. Today, we pinpoint only four: Safety, Health, Financial Security, and the Quality of Life.

1- Safety: Hundreds of elderly women have been victims of purse-snatching, street assaults, and even rape in their own homes. We recommend continued funding for domestic violence and rape crisis centers and the promotion of public awareness of crimes against elderly women. We would like to ask your support also of the Victim Witness Assistance Programs which would make victim impact statements available to judges when legal proceedings begin and would also make services available at every solicitor's office in the state (not just the 4 now in operation in S.C.).

2- Health: We urge additional research concerning health problems of the elderly - focussing especially on illnesses that deter the self-esteen and self-care of women. We encourage medical research into alternatives to the current reliance on tranquilizing drugs.

3- Financial Security: We applaud your recent recommendations for legislation which has eased the tax burden and supplied some services free and at reduced costs.

We urge your consideration of the 21.9% of the elderly who live below the poverty level, almost all of whom are women. As late as 1950, the labor force was composed of only 30% women and these were in the lowest paying categories. These women now make up part of our elderly population, some of whom suffer a double jeopardy of racism as well as sexism.

4- The Quality of Life: Like Maggie Kuhn of the Gray Panthers, we believe that just "obtaining services is like Novocain - it dulls the pain, but doesn't solve the problem." The University of California recently released a study showing that elderly people enjoy an enriched and stimulating mental activity. Thus, the cliché that older people's mental activity runs down is not true. The elderly need activities and mutual support designed to make the second half of life a creative, spiritual adventure. Learning a new trade could relieve self-centeredness and boredom that breeds illness and senility. Courses designed especially to meet the needs of elderly women are greatly lacking.

During the 14 years that you and your predecessors have studied services, programs and facilities for the aging, you have made continuous progress on behalf of the elderly citizens of South Carolina. All have been for assistance for men and women.

The Commission on Women agrees implicitly with the principle that prompted your handbook, South Carolina Boards and Commissions, Opportunities for Older Citizen Representation. We have a similar project called the Talent Bank which encourages the appointments of capable women to S.C. Boards and Commissions. We would like very much to see more women serve on this Study Committee on Aging. (Since 1959 only seven women have served on this committee whose constituency is 61.3% women).

We offer our assistance in providing equity in representation.

We also offer our support in publicizing and gaining endorsement for any legislation beneficial to elderly women which falls within the parameters of our statute.

The S.C. Commission on Women greatly appreciates the opportunity of making this presentation today.

We wish you continued success.

Ms. Maxine Fallaw
Senior Citizen
Columbia, SC

This testimony addressed the matter of reverse mortgages, which are available in other states. Ms. Fallaw did not know any details about this procedure but asked the Committee to research this matter.

Senator Rubin remarked that banks and institutions can purchase the house now.

Ms. Fallaw replied that they are not doing it in South Carolina. She has heard of cases, however, when houses were bought but then they did not let the previous owner stay, they made the owner move. She mentioned that she had sent Mrs. Bumgardner some information which she had received from a S. C. institution.

Senator Rubin said that the Committee will have to explore in greater detail the specifics of this matter.

Ms. Maxine Fallaw, Senior Citizen
Columbia, SC.

Am older And Cannot work, would like to see the reverse Mortage available in S. C. Yes in S. C. that are senior citizens need this type of serice in so Many ways.

Other states have had this Reverse Mortage for a number of years

I have my house almost paid for and would like to stay in it until I leave this world.

It is for the neighbor hood also, as I have been here a number of years. The area is small and very quiet.

It is very safe so far here, as every one keeps watch out for others.

Am close to shopping center that has everything I need.

Have enough yard and can hear the birds and bees. As we all need to be able to get out and walk. Sheriff department and fire hydrant are here and give me a piece of mind.

Ms. Kathy Riley, Associate Director
Providence Home
Columbia, SC

Providence Home offers shelter and food to people with little money, no caring family and no support systems to lean on. In the past year, more elderly persons have come to live with them than ever before. These could be deserted elderly, mentally ill elderly or displaced elderly. They all have one thing in common--nowhere else to go. Many come from hospitals, State institutions, some are referred from DSS.

Ms. Riley referred to the need of coordinated services especially between the Department of Mental Health and the Department of Social Services. She knows of numerous occasions when people staying at the Providence Home had several social workers involved in their lives, and they never talked to one another. She asked where the treatment plan is.

Other concerns came about from calls she receives at the shelter during a day:

1. There is a great need for lifeline telephone rates for senior citizens.
2. A policy needs to be developed with the utilities to prevent winter cutoffs for the elderly.
3. More homemakers are needed.
4. The Committee needs to look at the recent cutbacks in the Medicaid Program as they affect prescriptions, number of days in a hospital and number of doctor visits.
5. Transportation is the most critical need of all the community-based services.

She asked the Committee to come and visit the shelter and see for themselves the kind of people who seek refuge there. "When they are with us, they are at the court of last resort, and they have lost all caring people in their lives."

In conclusion Ms. Riley said that "you have some street people in Columbia, and they are over the age of 22."

In a question and answer session, it was brought out that the shelter presently houses 16 women and 20 men (housed in 2 shelters) in addition to the ones they feed coming off the street. The Providence Home does not get any financial support through the United Way nor are there any Federal or State monies going to them, 100 percent of their money comes "from begging."

Senator McLeod informed Ms. Riley that he started to introduce legislation last year dealing with power cutoffs, and when he asked Legislative Council to research this, they sent him a copy of the Public Service Commission's regulations which spelled out the same thing that he had in mind and did not know it was already in effect. He questioned what goes wrong.

Ms. Riley explained that there are thousands of cutoffs per year. She thinks that sometimes it is caused by a breakdown in the system--a mistake. "What I would like to do is have them reminded periodically."

PROVIDENCE HOME

MEN'S SHELTER
3421 Main Street
Columbia, SC 29203

WOMEN'S SHELTER
3425 N. Main Street
Columbia, SC 29203
779-4706

FARM
Route 2
Gaston, SC 29053
775-1194

O. John Zenoni
Executive Director

Kathy Riley
Associate Director

Ladies and Gentlemen,

My name is Kathy Riley. I am the Associate Director of Providence Home. My every day work puts me in touch with people who have little to no money, no caring family and no support systems to lean on. People come to Providence Home looking for shelter, for food - for all the things the material poor need.

I have taken my time to come here today to share my stories, my concerns. I also come with questions concerning the care of the elderly and possible solutions.

Providence Home has housed many men and women in need of emergency shelter. These people have not always been the young and the unemployed. This past year I have seen more elderly live with us than ever before. The situations have varied from deserted elderly to mentally ill elderly to displaced elderly. The common denominator among all has been - they had nowhere else to go.

Where do these elderly residents of Providence Home come from? Many come from hospitals and state institutions or referrals from the Dept. of Social Services. Sometimes they just appear on our doorstep assisted by a policeman saying, "If you take her we will not have to lock her up."

Life for some of the elderly citizens of Columbia and South Carolina is less than desirable.

My experiences at Providence Home have taught me that greater communication must be obtained between the Dept. of Mental Health and the Dept. of Social Services. I can cite many instances for the need of coordinated services between these two agencies. There are many elderly living in certified community care homes where there is little to no treatment plan arranged for the individual. I've known actual cases where a person might have two to three social workers involved in their life - but the workers never talk with each other because they represent different state agencies.

Other concerns I bring with me center not around the people who come to our shelter but the numerous calls I receive in a day from the elderly. My worries and solutions are:

1. With the deregulation of the telephone company we can expect increases in the base rates. Now more than ever there is the need for affordable lifeline rates for the elderly. We must insist that a telephone is not a luxury to a senior citizen...it is a lifeline and rates should reflect this. You are responsible for the election of the PSC members. WE NEED a caring commission to represent the elderly and not only the concerns of big business.

2. Following the thought of what should be expected of a commission member - utilities must be made aware that NO senior citizen should freeze. I would ask that a policy exist which allows no winter cutoffs of the elderly.

PROVIDENCE HOME

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O. John Zenoni
Executive Director

Kathy Riley
Associate Director

3. There is a need for more homemakers.

4. Please look at the recent cutbacks in the medicaid program. These cutbacks effect prescriptions, length of stay in a hospital, the number of doctor visits. By these cuts we are not into preventive care but forcing the elderly to seek medical care when the illness is advanced.

5. We need to fund community-based services. Transporation is a critical, and costly need for senior citizens.

I'm sure these are just a few of the many needs of the elderly. My presence here today I hope would be taken to show that there are many elderly whose needs are not being met. Believe me it is sad for me to work with the many people who come to us seeking help - they are called "street people" by some... know that there are also elderly "street people" ... the hardest one to place, the hardest ones to serve. We, I need the hepl of you. Come visit me. I promise to open your eyes to someone elses mother, grandmother.

Dr. Alan Edwards, Member
Legislative Forum
S. C. Federation of Older Americans

The following concerns were presented:

1. Probate Code Reform.
2. Extension of services for home health care to all physically impaired elderly.
3. Access to health care services of all state-licensed health providers, regardless of method of payment.
4. Inflation in medical costs.
5. Increased taxation of homes.
6. Proposed increases in electric and telephone services.

Statement from Legislative Forum of S. C. Federation of Older Americans by Allen D. Edwards on Sept 23, 1983

The Legislative Forum is composed of retired teachers, retired State employees, retired federal and Military personnel, area agencies on aging and staff members of State Agencies concerned with problems of older South Carolinians. The purpose is to become knowledgeable concerning issues affecting the elderly and of legislature and administrative efforts to deal with them.

We wish to express our thanks to the Study Committee for their efforts in behalf of the elderly. During the past session, we recognize especially the Condominium Conversion legislation, improvements in home health care, and our present bonus for retired teachers and retired State employees.

Some of the concerns which we have are as follows

1. Probate Code Reform. We regard this legislation to be extremely valuable to all persons involved in the settlement of estates.
2. Extending the services for home health care to all physically impaired elderly regardless of the ability to pay.
3. Access to health care services of all state-licensed health providers, regardless of method of payment
4. Inflation on cost of hospital and other medical services, increased taxation of homes, and proposals to increase cost of electricity and telephone service.

Allen D. Edwards

Member, Legislative Forum, S.C. Federation of Older Americans

Mrs. Gloria Turner, Executive Director
Kershaw County Council on Aging
Camden, SC

Mrs. Turner gave an opinion of Community Long Term Care. She called CLTC nothing more than an expanded and reworded version of the old PSRO nursing home assessments. In her opinion an already existing agency should have been given the opportunity to hire extra staff and administer a CLTC program instead of implementing a new administrative agency. The function of CLTC is all administrative, there are no services provided. It is difficult to be an advocate for the elderly and support CLTC.

She suggests the following alternatives:

1. Compare CLTC with other agencies input and stop the waste of administrative money.
2. Boarding homes and adult day care centers are needed throughout the State. Find ways to establish these.
3. Realistic goals are needed, not more administration.
4. Channel proper funding to existing qualified agencies for their elderly programs.

Councils on Aging have had a long history of carrying out in-home services and with more money provided, they could go even farther.

One concern which is not in her written testimony, Mrs. Turner wanted to bring to the Committee's attention; i.e., Alzheimer's disease. This disease is causing more and more problems. Patients afflicted with Alzheimer's are considered custodial care, but nursing homes do not want them. This problem should be addressed by the State.

Senator McLeod told Mrs. Turner that a number of people at this Hearing have spoken very positively of the Community Long Term Care Project. He asked her to be more specific and get supporting data to the Committee.

Mrs. Turner told him that she will gladly supply data. Having worked for the PSRO, she feels she is more qualified to give an opinion of CLTC. She added that when you look at the staff of the CLTC, you don't find any elderly persons, "and those are the people referring services out. I think this is something that should be looked at, and I will be glad to show any data for my opinion on it."

Representative Blackwell remarked that Mrs. Turner makes a rather strong charge by saying that "what is in the best interest of the elderly is not the goal of the CLTC. What are you saying, that the bottom line figures are just numbers?"

Mrs. Turner replied that partly, yes, that was true. At the end of the year, CLTC will have to justify how many people they kept out of nursing homes and put back into the home. "We have been doing this for years. We know what the needs are. We need more money to furnish the needs."

Representative Waldrop asked her if she thinks that we are building a dynasty with the new Commission we are forming or does she think this money should go back through the Councils on Aging to help the people.

Mrs. Turner replied that she does not care through what agency the money goes, if the services are there. In her opinion we are just getting another administrative agency to tell the agencies what to do. "We are answering to the Board, the AAA's, to the Commission, now we are getting referrals from CLTC--yet nobody is seeing that we get more funds."

"An Opinion of Community Long Term Care"

I appreciate the opportunity to speak before this committee. My name is Gloria Turner. As the Director of the Council on Aging in Kershaw County, a member of the S. C. Association of Council on Aging Directors, a registered nurse and a former employee of PSRO, I feel that I am qualified to express an opinion on Community Long Term Care.

Despite any pilot projects, Community Long Term Care is a newly organized administrative group that started statewide in 1983. CLTC is nothing more than an expanded and reworded version of the old PSRO Nursing Home assessments. In 1979, in certain areas of the state, prior approval by PSRO had to be obtained before admission to a nursing home. Now in 1983, it is state wide and called Community Long Term Care.

It is hard to understand why another agency that already existed was not given the opportunity to be designated to hire extra staff and administer a CLTC program. Instead, a new administrative agency was implemented, office space had to be obtained and salaries for administrators, social workers and registered nurses were set up in each region. CLTC is all administrative with no services provided.

The money that has been allocated for CLTC could have been given to existing service providers who could have provided much less costly administration and use the money for more services for the elderly. These agencies could have done this in their existing office space.

It is hard to be an advocate for the elderly and support CLTC. What is in the best interest of our elderly is not the goal of CLTC. Bottom line figures are the goals of CLTC.

When someone is referred for nursing home care to CLTC and they refer the client back to us for services (that we are already providing) it is frustrating. None of us, other than a nursing home or licensed boarding home can give 24 hour service. To say that volunteers can be recruited to help with the care of these people daily for 24 hours is a fallacy. We service providers may have visions of people helping others each day, day after day but we also deal with the reality of the facts

What are alternatives:

1. Evaluate CLTC with other agencies imput and stop the waste of administrative money.
2. Find proper solutions to obtaining boarding homes and Adult Day Care Centers throughout our state that are so badly needed.
3. Set realistic goals, not more administration. (We don't need new agency to tell us what existing agencies already know needs to be dot In other words, less Chiefs and more Indians for provider services.
4. Look at existing agencies who are qualified and get proper funding for elderly programs to be carried out.

"CLTC" These letters are suppose to stand for Community Long Term Care.

In supporting the rights of the elderly it should read:

"CLTC" - Costly Lousy Treatment for Clients

Mrs. Emily A. Canine, Executive Director
Newberry County Council on Aging
Newberry, SC

This statement presented an overview of an aging agency in a rural area.

One of the concerns addressed the proposed increase in the cost of telephone calls.

The Newberry County Council on Aging, as well as many other Councils on Aging in this State, has been providing needed, in-depth services to frail elderly for several years now with all of the required backup material and procedures. All they need is funding to expand these home services, already in place, so that they can care for more fragile senior citizens.

Mrs. Canine asked that at least one Geriatric Center be opened in South Carolina and that the medical schools require geriatric training for new doctors.

She ended her presentation by proposing to the Legislature that funds earmarked for a new Community Long Term Care Program should be channeled through existing community programs of the long-time aging network.

Senator Rubin thanked Mrs. Canine for a very comprehensive report and commended her on her services.

Newberry County Council on Aging
1304 HUNT STREET
Newberry, South Carolina 29108

EMILY A. CANINE,
EXECUTIVE DIRECTOR

TELEPHONE 276-8266

Presentation before Legislative Committee on Aging

Friday, September 23, 1983 3:10 p.m. - 3:20 p.m.

Emily A. Canine, Executive Director

Honorable Legislators and Friends:

The Newberry County Council on Aging is thirteen years old. We have a staff of 23 people, 12 of whom, are 55 years and older. Our average, full-time, yearly salary for staff members is $8,200. We are funded with Federal, State, County, City and United Way monies. We also receive donations for our programs from individual churches, civic groups, service clubs, the Inter-faith Council and interested citizens. There are three senior centers in Newberry County - a large, Multi-Purpose Senior Center; a Center for the local Federal Housing Development; and a Center in the town of Whitmire. A total of 115 Congregate meals are served, daily, among these three centers. There are planned monthly programs at each Center with news and education addressing the interests and concerns of seniors in areas of finance, the law and welfare, health and medical care, recreation, nutrition and home care - and, our ladies make beautiful quilts. We provide transportation to Senior Centers, to adult education classes, for doctors' appointments, shopping, to banks and to pay bills, for pleasure trips and to special days at the state Zoo and the State Fair. Our Retired Senior Volunteer Program (RSVP) is ten years old and counts over 275 active volunteers of 60 years and older, who serve all over Newberry County in the hospital, Newberry College, churches, libraries, senior centers, doctors' offices, other agency offices, the local government offices and polling places. A talented group of seniors goes to our two Nursing Homes each week to sing for the patients and to greet them, and to love them,

and to let them know that they are cared about and not forgotten. RSVP volunteers teach crafts, wood-working, crocheting, quilting and kindness to children in the Middle Schools and show them that "older can be fun." Ninety-six meals are delivered to the homes of frail, elderly shut-ins each day by a faithful corps of volunteers - many, of whom, are also seniors. We have fifteen elderly people calling 170 other seniors for support, and to break through the barrier of loneliness so that they have some human, daily contact. Our seniors make over 1,000 telephone calls a month, and we worry about what will happen to these seniors, if the cost of telephone calls is increased to the point where they can not afford this link with the outside world.

The Newberry County Council on Aging has five full-time, and, two part-time Homemakers, at this time. These well-trained people go into the homes of 60 frail, elderly people, on a regular basis, to provide personal care and to do light housework so that these delicate seniors may stay in their own homes and out of institutions. We have staff who are proficient in Case Management. They make outreach visits to prospective clients. The Case Managers assess the needs of the elderly and work up a complete assessment and evaluation report on each senior. A service plan is prepared and implemented from various services offered within the Newberry County Council on Aging, or when needed, coordination is arranged with other Human Service Agencies such as the Department of Social Services, the County Health Department, the County Mental Health office, the Veterans Administration, Social Security, Food Stamps, the Speech and Hearing clinic, the Care Center for Retarded Adults, the Drug and Alcohol Commission, local doctors, dentists, hospitals and Nursing Homes. In an area the size of Newberry County, Human Service providers are aware of people who need help and know of the programs and services offered by each agency. There is constant referral among these agencies to give human

care and support, when, and where it is needed. Once the services have begun, the Newberry County Council on Aging Case Management staff provides follow-up visits to these frail elderly, at regular intervals, to make sure the clients are reassessed for future needs, desires and interests and concerns. Our Case Managers keep records on all in-home clients and keep track of their progress and physical and mental conditions. The Homemakers make daily, written reports about their clients, and the supervisor checks these reports for any changes apparent in the client's health and general welfare. The Newberry County Council on Aging, as well as many Councils on Aging in South Carolina, has been providing needed, in-depth services to frail elderly for several years, with all of the required back-up material and procedures. All we need is the money to expand these home services, already in place, so that we may care for more fragile seniors.

We should like to ask that at least one Geriatric Center be opened in the State, and, that our medical schools require lengthy geriatric training for new doctors so that they may realize that one is not worthless at 60 years old and should be treated by doctors who are interested in improving their quality of life, not just in delaying death.

The Newberry County Council on Aging would like to open Senior Centers in other areas of Newberry County for the "well-elderly" and provide Congregate Meals, programs and transportation to a larger segment of our senior population.

I would, respectfully, like to suggest to the Legislature that they are funding new agencies and new programs at great new expense, which duplicate the services and clients already provided for, by the South Carolina Councils on Aging. I would propose that, instead of the Legislature designating large amounts of money for new community, long-term care types of administration and projects, these funds be channeled through the existing community programs of the long-time Aging Network, working effectively throughout South Carolina.

Mrs. Cora B. Wimberly, President
White Pond Community Group
Williston, SC

Mrs. Wimberly, who represents a group of 89 senior citizens from the White Pond Community, referred to her appearance last year at this Public Hearing and said that she will be presenting about the same problems. Since last year they have not received any services from the Council on Aging in their community.

When attending the Regional Aging Advisory Committee meeting this past spring, she presented her group's needs--which range from transportation to meals-on-wheels to recreational opportunities--but was told there is no money to reach out into rural areas.

She asked that the Committee see to it that "rural South Carolina gets some of the services I heard some of these beautiful ladies bring this afternoon."

(1)

Senate Select Committee on Aging

I am again here to speak for the elderly of South Carolina minority and for the white general community directly.

Again I want to inform this committee that the elderly of the white general community are not denied any service from the Council on Aging in our community.

I was invited to the Regional Caucus meeting this spring to represent the needs of our community. I was told that there is no money during the next two years for the elderly. We asked for priorities and interpretations were being made for the seven counties. No one knew what they were saying a meeting will be taken the next night.

the purchase of the community
[illegible] purposes.

Here is what the [illegible]
[illegible] told that they
didn't know it was coming
but they would insert my
name on their agenda. Of
the 89 names given the
[illegible] - Windsor area
that need service. 3/4 of
these people are 65 and
over. She was very angry
when I left & [illegible] informed
me during the
meeting that the Dutch
council on Aging was
open on the Avon City
Residents. It wanted the
new Hero was the council
on Aging, Funded. It cleaned
it was [illegible] funded.
When I had them to
show that the they made
my [illegible] it should be avoided.
[illegible] and Senior Citizens
[illegible] for the money
to Avon citizens. For it

I have been retired 7 (5) yrs. and I have to [illegible] much of my time to provide for [illegible] [illegible] work.

For instance many times I don't receive energy assistance in the food commodities until a few (4-5) [illegible] I have to go to work shops and learn the procedures and [illegible] it done in my community.

Ms. Suzanne Lewis, Acting Director
Division of Volunteer Services
Office of the Governor
Columbia, SC

This testimony gave an overview of the Governor's recently designated Division of Volunteer Services in his office. Knowing that volunteers are a dependable and productive resource prompted him to commit staff to promote, advocate and provide a focal point for volunteer initiatives in South Carolina.

The 1981 Governor's Council on Volunteerism and the 1982 Governor's Resource Panel for the Elderly recommended specific action which this new Division will carefully consider.

A Volunteer Program Manual for state agencies will be forthcoming from this office in early October. This manual is the result of work done by the Council on Volunteerism.

Ms. Lewis added that the Governor supported the House and Senate Bills last year which allowed for the 18 cents per mile state income tax deduction for volunteer services.

Senator Rubin assured Ms. Lewis that the Committee will work with her. "This is the age of the volunteer."

Testimony by:
Suzanne P. Lewis, Acting Director
Division of Volunteer Services
Office of the Governor
September 23, 1983

I appreciate this opportunity today to bring to your attention Governor Riley's recent designation of a Division of Volunteer Services within his office. His continued support of volunteerism and his understanding that volunteers can be a dependable and productive resource for providing services and in promoting positive social change in S. C. led him to commit staff to promote, advocate and serve as a focal point for volunteer initiatives. He created the office to carry out the following responsibilities:

1. Act as an agent for planned change in the structure and use of volunteers in the public sector.

2. Identify and promote initiatives which will increase and continue effective volunteer use in the public sector.

3. Develop a system for the dissemination of resource materials and information on volunteer program planning and current activities at the state, federal and local level.

4. Act as an advocate for volunteer initiatives throughout the State.

5. Provide a forum for the research and study on volunteer issues which impact current volunteer utilization.

For the next six months or so the Division will focus on activities which promote and facilitate increased utilization of volunteers in our state agencies and their local components. Both the 1981 Governor's Council on Volunteerism report and the 1982 Governor's Resource Panel on the Elderly report recommended specific action which the Division will carefully consider as it moves ahead with its work. This office will also continue work in the area of citizens participation in education and focus increased attention to the role of school advisory councils.

Testimony
Public Hearing
Joint Legislative Committee on Aging

A volunteer program manual for state agencies will be forthcoming from our office in early October. This manual is the result of the work done by the Governor's Council on Volunteerism and edited and published by the Division of Volunteer Services. It will assist the agencies as they commit new or increased efforts to volunteer program planning and will be available to the state agencies and their local or district offices.

At this time let me say that Governor Riley supported the House and Senate bills which allowed for an 18¢ per mile state income tax deduction for travel expenses related to volunteer services for a charitable organization. S.25 passed the Senate in 1983 and we will continue to support passage in the House in the up-coming session.

As we proceed with our work, we will solicit the input and participation of the many leaders in voluntary action in S. C. We will keep you updated on volunteer activities and initiatives which will impact the elderly in the State.

Ms. Judith Ann Fickling, Executive Director
S. C. Nurses' Association
Columbia, SC

This Professional Association of 13,500 registered nurses in South Carolina has been very much aware for some time of the increase in chronic diseases, costs of medical care and institutionalization, as well as the growing number of persons over 65.

They believe in the benefits of community home health services and passed a resolution to "support legislation to maintain and develop long term care for all persons in need of those services and to support quality home health nursing standards."

The Association urges continued legislative support for the Community Long Term Care Program as they believe that community-based services can be more effective and less costly.

In response to Mrs. Turner's testimony (see pages 109-112) she asserted that during the time she was with the PSRO she found that "large numbers of patients in nursing homes were inappropriately placed and as a result of that, patients were having to wait long periods of time in the hospital for nursing home beds to such an extent that their Medicare benefits were exhausted and they then became Medicaid eligible and had to be picked up by the State."

Ms. Fickling reminded the Committee of the nurse's role in delaying or preventing institutionalization. Many times the Registered Nurse is the only accessible health care provider, because she will make home visits.

She offered the Association's knowledge, experience and support to the Committee to help in its efforts to develop health care policies for effective and efficient delivery of services to the elderly.

Senator Rubin inquired about the supply of nurses and whether the shortage is improving.

Ms. Fickling said that it was improving in the urban areas to the extent that there is an oversupply; however, in the rural areas there is still a shortage of Registered Nurses. As a result of the undersupply, several two-year nursing programs were opened in the State over the last two years. This is helping, but the move right now is to make this a four-year program. However,

this may create a problem for those nurses with a two or three-year nursing program and, in order for them to practice as a Registered Nurse, they have to go back to school. This, of course, would have to be mandated by the Legislature.

Senator Rubin anticipates resistance to this.

Ms. Fickling thinks that the problem is caused by the fact patients are leaving hospitals sooner in a sicker status because of the DRG, which determines payment right now. Further, patients now going into hospitals--because they live longer and are getting older--may have several conditions (instead of one) which require such an extensive knowledge of medicine, nursing and pharmacy that a two-year program in nursing is not sufficient any more.

In closing Ms. Fickling stated that the Nurses' Association in this State as well as other states and the American Nurses' Association are supporting the four-year program for the Professional Nurse but not for the Technical Nurse.

Dr. Parrish asked for the difference between a Technical Nurse and a Professional Nurse.

Ms. Fickling explained that it would be in the decision making, the nursing judgment.

South Carolina Nurses' Association

1821 GADSDEN STREET
COLUMBIA, SOUTH CAROLINA 29201
TELEPHONE 252-4781

TO: The Joint Legislative Study Committee on Aging

DATE: Friday, September 23, 1983

PLACE: Room 101/109 Blatt Building
Columbia, South Carolina

Good afternoon. I am Judy Fickling, Executive Director of the South Carolina Nurses' Association, the professional association for registered nurses.

For some time, the South Carolina Nurses' Association has recognized the increasing incidence of chronic disease, the increasing costs of medical care and institutionalization, the increase in the percentage of the population over 65, and the relationships of these phenomena. We have publicly stated our belief that community [redacted] home health services provide a viable alternative to institutionalization and that these services allow for maximum self-sufficiency, independent living, quality of life, family life continuity, and death with dignity.

At its 1982 House of Delegates, the governing body of the SCNA, along with the Board of Directors, passed a resolution to "support legislation to maintain and develop community long term care for all persons in need of those services," and to "support quality home health nursing standards."

The Community Long Term Care (CLTC) demonstration is now evaluating the mix of services that can be more effective and less costly than nursing home care. We urge continued legislative support during the demonstration and evaluation because we believe that community based services can be more effective and less costly, and that by reducing the growth of long term care expenditures by Medicaid and by individuals, more persons can be served at lower per capita costs.

We want to take this opportunity today to remind you of the nurses' role in delaying or preventing institutionalization and the nurses' role in helping the individual maintain as normal a lifestyle as is possible. Many times the registered nurse is the only accessible health care provider, because she will make home visits, and the individual relies upon the nurse for health care knowledge, judgment, and education, as well as for emotional support, nutritional counseling, and coordination of intervention by other practitioners, e.g. physicians, pharmacists, social workers.

Nurses are in the mainstream of health care delivery. They have more frequent and more intensive contact with patients and clients, and are, therefore, very knowledgeable about the total health care needs of the individual, transcending a physical or mental focus. Nurses provide the missing link in the study and delivery of health care services.

However, nursing knowledge and practice have continued to be ignored or overlooked in the development of health care policy for the very people we are talking about serving. There may be no other group of health care professionals who have a better appreciation and understanding of the needs, concerns, problems, and exigencies of growing old and being elderly than the 13,500 registered nurses working in South Carolina. We are offering their knowledge, their experiences, their insight, and their support to you in your effort to develop health care policy for the effective and efficient delivery of services to our parents and grandparents.

Jt. Legislative Committee on Aging
Public Hearing
Sept. 23, 1983

Dr. Ernest Furchtgott
Department of Psychology
University of South Carolina
Columbia, SC

This testimony addressed the need for the establishment of a Center for Gerontology. Most states in the Southeast have organizations--several states have actually more than one state-supported organization--associated with their educational institutions dedicated to training and research in gerontology. Dr. Furchtgott listed among others the University of Alabama Center for the Study of Aging, the Duke University Center for the Study of Aging and Human Development, the Virginia Polytechnic Institute Center of Gerontology, in fact, Virginia has three Centers. South Carolina does not have a Center; however, representatives from two major research universities, Clemson and USC, have met and come up with a joint proposal for the establishment of a SC Gerontology Center. The Medical University has been invited to join the planning sessions, but they are holding off until they can fill their Chair in Geriatrics.

The objectives ofthe proposed Center are 1) promotion of aging related research; 2) facilitation of technology and knowledge transfer from researchers to practitioners; 3)collection and dissemination of gerontological resources in the State; and 4)promotion and coordination of aging related instructional activities.

The Center will work closely with the SC Commission on Aging as well as with the Study Committee on Aging and the aging network. While the SC Commission on Aging does serve several of the functions described above, it has only limited resources to perform all of the functions foreseeable for the Center.

Courses, certificates and degrees in gerontology are currently offered by several colleges and departments. Clemson University has had an Institute for Senior Citizens since 1972, and the Clemson Extension Service has in place a state-wide information delivery network which could be of great benefit to the elderly. The proposed Center would be of significance in terms of research and service to the rural aged who have been neglected in this respect.

The Center will operate under the jurisdiction of the SC Higher Education Council for Gerontology. Much of its development will depend on a number of economic and social factors prevalent in SC in the next three years. During the third year the Center will be evaluated in terms of functions set forth under the objectives.

Dr. Furchtgott has spoken to members of state agencies serving the elderly and has received support from them. He thinks such a Center can be established with a minimal initial outlay and will in the long run actually save the State money in providing services for the elderly.

Senator Rubin asked for the difference between a Center for Gerontology and a Department of Geriatrics.

Dr. Furchtgott explained that the Department of Geriatrics is primarily concerned with the medical aspects of aging. However, many of the problems of the elderly are not only medical problems; there are social problems and demographical problems, which would be trying to find out how many people over 65 who are eligible for the homestead exemption are actually taking advantage of it. At Clemson and at USC there is personnel in demographics, sociology, psychology, economics, public health, nursing, social work, etc., all of whom have expertise in these various problems of aging. The Center would cover the whole spectrum instead of just the medical aspect.

Senator Rubin wanted to know where the Center would be located.

Dr. Furchtgott replied that they discussed this with the representatives from Clemson and everybody involved agreed that it could be either at Clemson or USC.

Testimony Presented at the

South Carolina Legislative Study Committee on Aging

Senator Hyman Rubin, Chairman

September 23, 1983

by Dr. Ernest Furchtgott

There is no need for me to present to this knowledgeable Committee the demographic changes in South Carolina. Also, you heard about problems of the elderly pertaining to a variety of disciplines, medicine, mental health, housing, crime, to name just a few. Thus, we see that there are a variety of major social consequences of this increase in our older population. The lead article of the October 1978 issue of The Gerontologist, an official publication of the Gerontological Society, was devoted to the "graying" of the federal budget and its consequences for old age policy. It is difficult not to be aware of the major national concerns about our Social Security system resulting from changes in our demographics. In 1978 the secretary of HEW also addressed this issue in a talk entitled, "The Aging of America: Questions for the Four-Generation Society." In short, problems of our aging populations raise issues on both the national as well as local levels which need to be addressed in terms of education as well as research and development.

Governor Richard Riley in his analysis of the educational needs of South Carolina has indicated that the problems of the aged should have a high priority. Most states in the southeast have organizations, several states have actually more than one state supported organization, associated with their educational institutions devoted to training and research in

gerontology. Below is a listing of several of these organizations:

University of Alabama Center for the Study of Aging,

University of Alabama in Birmingham Center for Aging,

Duke University Center for the Study of Aging and Human Development,

University of Florida Center for Gerontological Studies,

Florida State University Multidisciplinary Center on Gerontology,

University of Georgia Gerontology Center,

Georgia State University Gerontology Center,

University of Louisville Gerontology Center,

Memphis State University Center for Life Cycle Studies,

University of Miami Center on Aging,

Norfolk State University Gerontology Center,

University of South Florida Suncoast Gerontology Center,

Virginia Commonwealth University-Virginia Center on Aging,

Virginia Polytechnic Institute Center of Gerontology.

South Carolina does not have a center for gerontology. Clemson University has an Institute for Senior Citizens. Its main functions, however, to hold summer camps and to develop recreational programs. When the Center proposed below is established, the Institute will be incorporated in the new Center.

We realize that the State of South Carolina has limited resources. In a spirit of unusual cooperation, representatives from two major research universities in the State, Clemson and the University of South Carolina, have met several times and have come up with a joint proposal for the establishment of a South Carolina Gerontology Center. We have also been in contact for the past two years with the Medical University of South

Carolina in Charleston. They have been invited to join our planning sessions. However, they are holding off until they can fill their Chair in Geriatrics. Other educational institutions in the State which have major resources in gerontology may also be invited later on to join the Center.

Objectives of the Proposed Center

The major functions of the Center will be in four areas:

1. Promotion of aging related research.
   a) The Center will assist faculty members in obtaining resources for research by serving as a referral source for grants and contracts.
   b) It will facilitate contacts between faculty members who may be jointly interested in interdisciplinary or large scale research projects.
   c) It will serve as a clearing house for contact with individuals who may be available as a research participant for specific projects.
2. Facilitate technology and knowledge transfer from researchers to practitioners.
   a) The Center will disseminate immediately applicable technology and knowledge to service providers via newsletters, seminars and workshops.
   b) It will help in the analysis of data collected by state agencies needed for policy implementation.
   c) It will serve as a resource center for providing specific technical information not currently available.

3. Collection and dissemination of gerontological resources in the state. The initial task will be to collect and disseminate information on resources pertaining to and research which are available in institutions of higher education in South Carolina. Existing information such as that collected by the South Carolina Commission on Aging will be incorporated into any reports. The Center will work toward the development and maintenance of a partnership with state and local agencies on aging.
4. A subsidiary goal will be the promotion and coordination of aging related instructional activities.
   a) The Center will assist in the development of courses and curricula at the undergraduate as well as graduate and professional level for full-time students as well as for individuals who are employed and wish to obtain formal training in gerontology.
   b) It will assist students in pursuing educational programs, field placements and training opportunities in gerontology.
   c) It will assist state agencies and others in developing continuing education programs for personnel serving older individuals.

While the South Carolina Commission on Aging does serve several of the functions described previously, it has only limited resources to perform all of the functions envisaged for the Center. Also, for several of the problems it is not economical for the Commission to have full-time specialists. Many faculty members have assisted or are already assisting state agencies and organizations serving older individuals with some of the

previously described activities. These efforts, however, have not been systematic. Also, agencies and organizations have frequently been unaware of the availability of the technical expertise in our institutions of higher learning. The proposed Center will facilitate communications between researchers and knowledge utilizers.

The Center will work closely with the South Carolina Commission on Aging as well as the joint Legislative Study Committee on Aging and the Aging Network.

Clemson University and USC have a large number of faculty members with teaching, research experience, and publications on diverse facets of gerontology. Included at USC are members of the colleges of Business Administration, Education, Health, Law, Nursing, Public Health, Social Work, and departments of Biology, Physical Education, Psychology, Sociology and Preventive Medicine. Currently there are several research projects in programs pertaining to problems ranging from biology to social aspects of aging. The Department of Psychology had a gerontology research initiation project supported by the National Institute of Aging. This grant had led to other projects, one of which is currently supported by the National Institute of Mental Health.

Courses on different aspects of aging and age related problems are currently offered by several colleges and departments.

The Graduate School offers an 18-semester hour interdisciplinary Certificate in Gerontology. The College of Nursing offers a minor in Health of the Aged.

In the College of Social Work the student can direct his/her studies

toward work with the aged. In the Department of Psychology the student can obtain a M.A. or Ph.D. degree with an emphasis in gerontological psychology.

The University libraries have very good collections in gerontology. Since 1978 USC has had an Advisory Committee for the Certificate of Gerontology. This committee has members representing the University as well as other agencies and citizen groups. An academic subcommittee has been meeting regularly and it has been dealing with general problems of gerontological training. The University is an institutional member of the Association for Gerontology in Higher Education.

Clemson University has had an Institute for Senior Citizens since 1972. Its objective include activities in the areas of housing and health care, recreation and education, nutrition, bio-medical technology, physiology of aging, and socio-economic and demographic aspects of aging. The Institute has been conducting an annual summer camp for senior citizens. Faculty members representing the Colleges of Agricultural Sciences, Nursing, Parks, Recreation and Tourism, and the departments of history, psychology and sociology, among others have published and/or taught courses in gerontology. A "Perspectives on Aging" conference was organized in 1981 by the Department of History. A member of the Department of Psychology is a major contribution to a research grant funded by the National Institute on Aging.

The Clemson Extension Service has in place a state-wide information delivery network which clearly could serve the elderly. This service is highly program-oriented and prepared to develop and deliver materials to

specific target audiences. Since South Carolina is a rural state with many aged and the rural aged have been a neglected population in terms of research and services, the proposed Center would be of especial significance.

Currently Clemson University offers courses in gerontology in the areas listed above.

Organization of the Center

The Center will operate under the jurisdiction of the South Carolina Higher Education Council for Gerontology. Any full-time faculty member or research associate of the participating Institutions, may become affiliated with the Center. Since we are in a period of financial exigency, the initial director of the Center will have to be a full-time USC or Clemson faculty member whose normal duties permit her/him to assume direction of the operation on a part-time basis. Such an assignment would not differ from other similar assignments currently performed by directors of other USC centers, programs and service organizations. The director will be assisted by an administrative assistant-secretary. In brief, the latter would be the only additional new personnel cost to the University.

Cooperative Arrangements with Other Educational Institutions

Initially, the University of South Carolina and Clemson have many faculty members who have interests in gerontology. Faculty members at these institutions who have major teaching and/or research interests will be encouraged to affiliate with the Center. Faculty members at other institutions may also become affiliated. Models for joint Gerontology Centers involving major universities which are geographically separated are

available. For example, Wayne State University, the University of Michigan and Michigan State are collaborating in the Michigan Gerontology Center. Once the Center is established, cooperativae arrangements with other institutions in the state can be developed.

As was indicated previously, the demand for gerontological services is steadily increasing. There is no educational institution, state agency or private organization in the state which has the personnel which can provide teaching, research and consultation in all of the diverse areas which bear upon gerontology. The listings of the various units at Clemson and USC which already have trained personnel interested in providing social services, reflects the scope of gerontological problems. There is at the present no mechanism to facilitate the optimal use of this personnel. The proposed Institute, modeled along other successful Institutes should provide better use of existing resources in gerontology in South Carolina.

Criteria of Evaluation

During the third year the Center will be evaluated in terms of functions set forth in the Objectives section. In general the evaluation will depend on feedback from university administrators, faculty members, the aging network in South Carolina, and other state agencies which provide services to older citizens as well as members of the media. Questionnaires will be distributed to determine the extent to which the Institute has provided services which were of benefit to service providers or the public. It should be noted that the evaluation will be a guide for the activities which the Institute shall pursue in the future. Since this outline has incorporated a very large number of functions, some of them will have to be provided only minimally, while others may be developed to a

much greater extent. Much of the development of the Institute will depend on a number of economic and social factors which will prevail in South Carolina in the next three years and some of which are difficult to predict.

We hope that your committee will have an opportunity to study this proposal and see fit to support it. I have already spoken to members of various state agencies which serve our older citizens and have received support from them. Included are chief program representatives for services for the elderly in the Departments of Health and Environmental Control, Mental Health and Social Services. As I have testified last year already, may I emphasize that I believe that with an absolute minimal initial outlay a Center of Gerontology representing a consortium of state-supported institutions of higher education can be established. Such a Center would, in the long run, or even in the short run, actually save the state money in providing services for the elderly. A major function of such an organization would be to assist agencies in the dissemination and utilization of technologies and policies.

Ms. Joan Snyder, Director
Project LOVE
Irmo-Chapin Recreation Commission Aging Program
Irmo, SC

This presentation gave an update on the services provided by their aging program along with an updated report on their Project LOVE (Let Older Volunteers Educate). This Project, which was started last year and is an intergenerational learning experience, will be expanded to a third school. Of course, this expansion as well as continuation within School District 5 is contingent upon some funding from the school district. If this does not come through, Project LOVE will become an extracurricular activity.

Aging Programs have been doing case management services for many years. In 1982 this Commission upgraded their case management system, and there has been an increase in coordinated interagency planning of services which should eliminate costly duplication of services. She questioned why a new agency has been established to coordinate services which are already coordinated through a client information system. "There is a difference between Community Long Term Care and Community Based Long Term Care. Many agree with the concepts of Long Term Care but feel more emphasis should be placed on the adaptation and interpretation of Community Based Long Term Care as presented in the statement given by the National Association of Area Agencies on Aging."

In conclusion, Ms. Snyder encouraged the support of proposed House Bill, H-2364 as the aging network needs the increase in service funds recommended in this legislation.

REPORT TO STATE OF SOUTH CAROLINA

STUDY COMMITTEE ON AGING

The Irmo-Chapin Parks and Recreation Commission Aging Program initiated a comprehensive aging program in July of 1980 when Lexington County put the programs and services for older adults in the County under the administration of the two special purpose districts in Lexington County, the Parks and Recreation Commissions.

At the end of the first year, 500 unduplicated older adults had received services. In the record year 1982-1983, which we are completing this month, 1500 unduplicated older adults are receiving services.

The services offered by our Aging Program are: Transportation, Escort Service, Outreach, Case Management, Shopping Assistance, Information and Referral, Recreation and Educational Programs, Telephone Reassurance Program, Food Co-op Program, Blood Pressure Screening, and Meals on Wheels. At the present time no congregate meals are available in our area. A needs assessment, to be completed by the Area Aging Agency this year, will help determine the need of these services. These services are available by calling the Aging Program Center offices, one in Chapin at 345-2798 or the Irmo office at 731-0047. Several facts about the programs and services delivered by the Irmo-Chapin Aging Program are unique. There are few programs today which help the older adult's dollar go further. The food co-op started in the summer of 1981. This program gives the older adult $7.00 to $10.00 buying power for only $3.00. A co-op food bag purchased every two weeks gives the participant a variety of fresh fruits

and vegetables in smaller quantities ideal for one or two people. The food co-op program is funded with local funds.

Demand/response transportation is an ever growing need. Few agencies are able to respond to emergency needs such as trips to the doctor's office or transportation for older adults on a short notice basis. This is a unique feature about our transportation program. Fifteen volunteer drivers aid us with this type of transportation. The number of unduplicated people served in transportation services of all types this past fiscal year is 268.

Project LOVE - Last year I talked to you about an exciting intergenerational learning experience called Project LOVE (Let Older Volunteers Educate). I would like to bring you up to date on Project LOVE. To date there have been 45 Grandpersons (Older Volunteers) active in this project. These Grandpersons have given 1,230 volunteer hours. Last year 350 children participated in Project LOVE. The project has been active in two grade schools. The fourth and fifth grades at Chapin Elementary have participated for one and a half years, and the third grade at Irmo Elementary has participated for a half year. Ms. Sally Powers and Dr. Martin Weinrich of the University of SC presented information on the positive statistical results of testing in Project LOVE at the 35th. Annual Scientific Meeting of the Gerontological Society of America in Boston, Massachusetts on November 22, 1982. This testing which was done in 1981 showed the following conclusions and implications: Interest among the third and fourth graders in Project LOVE was high to begin with, and it increased over the school year. The fourth graders, who had direct experience with the Grandpersons showed more conversions to "positive" responses

than did the third graders, although the difference between the grades was not significant.

Changes in attitudes (as measured on the scale included in research) were almost nonexistent among the controls, and significantly positive among the fourth graders. The full analysis of covariance yielded an estimated treatment of 1.33, or almost 10% of the average posttest score, and strongly supports the hypothesis that children's attitudes toward old people are more positive after participation in an intergenerational program like Project LOVE.

These conclusions are reinforced by a reading of the students' own comments about Project LOVE which clearly demonstrates their appreciation of the benefits obtained from this intergenerational learning experience.

This study supports the value of intergenerational programs and policies that encourage utilization of one of our country's most valuable resources - our old people. As Margaret Mead (1978) points out, the need for intergenerational learning programs are developing. They are successful because old people need someone to relate to and there are young people who need old people to relate to. The potential benefits of intergenerational learning experiences for both old and young are great.

I am giving Keller a copy of an article which Sally has released for publication for additional information for the Aging Study Committee and have included in your packet some highlights of the study for your personal files.

Project LOVE has received the honor of being presented again this year at the 36th. Annual Scientific Meeting of the

Gerontological Society of America in San Francisco on November 21, 1983. This year I will be participating in a discussion in relation to integrating aging into the curriculum. (Abstract description is enclosed in your packet of information).

At the Southeastern Aging Network Conference in Savannah in November where the Community Based Long Term Care is the theme, I will be presenting Project LOVE in a workshop titled "Intergenerational Programming: An Emerging Resource in Community Long Term Care." They say education in a holistic way is considered to take place from the womb to the tomb. Holistically, real long term care can be viewed in the same light.

Future plans include expansion to a third school and continuation within School District #5 contingent upon some funding from the school district. If this does not occur Project LOVE will change pace and place and become an extracurricular activity from 3:00 PM to 5:00 PM within the Recreation Commission scheduled activities.

Aging programs have been doing case management services for many years. In 1982 we upgraded our case management system. Through our participation in a central client information system, clients are receiving quicker services. There has been an increase in coordinated interagency planning of services which should in theory eliminate the costly duplication of services and in many instances does. The tax payers will be asking many of us to explain why a new agency has been established to coordinate services which are already being coordinated through a client information system. Duplication of services will increase. With minor upgrading, the

Aging Network could have saved the state money. Does an agency infringe on the client's rights when authorized case management is already in place and another agency steps in and duplicates services? There is a difference between Community Long Term Care and Community Based Long Term Care. Who knows more about the client's needs? Would it be the agency which has worked with the client on the local level to coordinate and plan services over a number of months and years or an agency whose contact with the client is in the latter stages of impairment, the final days before the nursing home bed is given?

Many practitioners in the field agree with the concepts of Long Term Care but feel more emphasis should be placed on the adaptation and interpretation of Community Based Long Term Care presented in the statement given by the National Association of Area Agencies on Aging.

The Aging Network needs the increase service funds recommended in the proposed legislative House Bill #2364. I encourage your support of this legislation.

Ms. Valeria Boykin-Tate, Program Director
Legal Service for the Elderly
Columbia Urban League
Columbia, SC

For the past several years, the League has been awarded an Older Americans Act Grant by the Central Midlands Regional Planning Council through the S. C. Commission on Aging. This grant is being used to provide legal services to seniors in the Central Midlands Region with emphasis on Richland County residents.

Many of the elderly poor or near poor depend on government assistance programs. These programs are subject to government statutes, regulations and decisional laws. Senior citizens do not have the experience to "work" the system which often times they find frustrating and incomprehensible. This is where the League's legal service program aided them in securing their benefits and entitlements. Many seniors, also, need help in protecting their rights as tenants and landlords. The League assists in writing deeds and wills.

There are a variety of legal needs of the poor and near poor elderly, mainly in the area of consumer affairs and employment. Seniors need attorneys and paralegals who can advise and represent them. Ms. Boykin-Tate said that more legal service programs designed exclusively for seniors are needed.

Senator Rubin asked how many full-time staff people are at the League.

Ms. Boykin-Tate informed him that she is the full-time staff. There are two part-time persons assisting her.

Dr. Parrish wondered if the Urban League was aware of the number of para-professionals that some of the two-year colleges are graduating who might be useful to the League.

Mr. Boykin-Tate told him that they made contact wtih primarily the University of South Carolina and some of the larger schools in the area to get either interns or volunteers to give some support. She has not made contact with the two-year colleges, for example Columbia Commercial College and Preston College.

Dr. Parrish suggested Midlands Tec.

Ms. Boykin-Tate admitted that she had overlooked this resource and she will make use of it.

Columbia Urban League, Inc.

Thank you for allowing me to testify before your committee today. My name is Valeria Boykin-Tate, Program Director of the Columbia Urban League's Legal Services for the Elderly Program. The League has, for the past several years, been awarded an Older Americans Act Grant by the Central Midlands Regional Planning Council through the South Carolina Commission on Aging to provide legal services to seniors in the Central Midlands Region with primary emphasis on Richland County.

A good many older persons, particularly those who are poor or near poor, depend on government assistance to maintain life on a daily basis. The government systems set up to administer these assistance programs are a vast complex system of statues, regulations and decisonal law. For instance, the shelter of the elderly may be provided under Federal and State public and subsidized housing laws, and zoning laws. Securing medical assistance is often dependent on Medicare, Medicaid and laws regulating nursing homes. Nutrition is often secured by the Food Stamp program and nutrition programs established by other Federal laws. The source of their income is most probably Social Security and/or supplemental Security Income. The dignity of personal freedom and control of property is subject ot the vagaries of the law of guardianship, and involuntary committment.

To say that the elderly have difficulty getting access to these programs is an understatement. Seniors, more often than not, simply do not have experience in "working" the system. In truth many of them find it frustating and imcomprehensible.

Our legal services program has been active in helping Seniors "access" the system to secure their benefits and entitlements. This has entailed primarily administrative representation. In addition we have assisted seniors in protecting their rights as tenants and landlords.

Many seniors living on fixed incomes have found it difficult meeting their property tax obligations. We have assisted seniors in protecting their homes by securing tax relief. Older persons are particularly concerned about protecting their property and providing for an inheritance to those who will follow them. We have been writing Deeds and Wills for seniors to meet this need.

It is well to note that there are a variety of other legal needs of the poor and near poor elderly. There is a need for assistance in the area of consumer affairs. The elderly are easy prey for unscrupulous practices within and without the market place. Legal advice and representation is needed in this area. As more seniors re-enter the work force employment rights of seniors will become more important and advice and counsel will be needed in that area.

Providing seniors access to legal advice and representation is a major concern of the Columbia Urban League. I'd like to leave you with a couple of thoughts. Most elderly persons have a narrow view of legal problems often restricted to criminal matters, divorce, negligence and estate matters. Both seniors and people who provide services to them need to be educated to identify the legal components of government assistance programs, housing, health and consumer problems. Seniors need attorneys and paralegals who can advise and represent them. Since Seniors can't afford to pay for attorneys on Social Security and SSI, we need more legal services programs designed exclusively for Seniors.

The Columbia Urban League is making every effort to assist with the matters I've talked about. In conjunction with regular service delivery we have conducted short programs at Senior Centers and meal sites in order to educate Seniors on topics of interest and importance to them. We have scheduled a Senior Citizens Legal Conference which will offer the opportunity to gain information on several topics.

Again, thank you for allowing us to testify.

Respectfully submitted,

Valeria Boykin-Tate

September 23, 1983

Mr. George Dick, Second Vice President
National Association of Area Agencies on Aging
Columbia, SC

The position statement by the National Association of Area Agencies on Aging (N4A), which is on file in the Committee, is the product of over three years of work and supports the concept which the State of South Carolina has adopted; i. e., to provide increased quality of care for the frail elderly in this State's communities. However, Mr. Dick pointed out valid definitions within the statement which offer alternatives the State could take to meet the needs of the aging population.

1. On page 5, the definition of community based long term care as presented by the N4A is quite different from the S. C. Long Term Care Model. One notable element that is missing in the S. C. Long Term Care Project is "preventive" care. Mr. Dick stated that the aging network for the past ten years has operated under this definition, only they called it the "continuum of care."

2. On page 6 a list of current problems associated with service integration is given. He named a few of these:

A. Fragmentation of services and duplication of administrative responsibilities. The N4A recommends to strengthen the existing network of State Offices on Aging, Area Agencies on on Aging and County Service Providing Agencies. Another Attachment, Models of Community Based Long Term Care Systems, gives examples of four states where various aging agencies worked together to create successful statewide community based long term care systems.

B. Case Managmeent is an integral part of any long term care system. This point agrees strongly with the direction South Carolina is going and underscores the fact that S. C. Area Agencies on Aging agree fully with N4A's viewpoint that the Area Agencies on Aging must be involved to make sure that effective case management systems are put in place.

C. N4A supports all legislative action which provides "preventive" as well as "after" care of the aging. Proposed House Bill H-2364 should provide a much needed resource for development of services to the frail elderly in this State.

Mr. Dick closed his presentation by saying that N4A supports all efforts to build a strong support system for the elderly and that the foundation of this system currently exists within the network on aging.

Mr. Dick clarified the difference between Area Agencies on Aging and Councils on Aging. Area Agencies on Aging were a product of the Older Americans Act and came into existence ten years ago. However, they have been working to spotlight the County Councils on Aging so that they would be recognized by the older persons.

This concluded the Public Hearing.

Senator Rubin announced that the Committee will be in consultation in the near future as to when they will follow up with a Committee Meeting to evaluate the presentations.

Prepared by: Rose Mary S. Smith
Administrative Assistant
Senate Medical Affairs Committee

TESTIMONY PRESENTED AT THE PUBLIC HEARING OF
THE SOUTH CAROLINA STUDY COMMITTEE ON AGING
BLATT BUILDING, COLUMBIA, SOUTH CAROLINA
SEPTEMBER 23, 1983

Senator Rubin, members of the Study Committee on Aging, thank you for allowing me time to appear before you today. My name is George Dick and I come before you today as the Second Vice-President of the National Association of Area Agencies on Aging. I am here to present to you our Association's position statement on Community Based Long Term Care (ATTACHMENT I).

As most of you are aware, for the past few years, I have presented testimony to this important committee as the representative of the Central Midlands Regional Planning Council (our region's Area Agency on Aging). During those years I also worked very diligently within our State to help establish a long term care system which could address the true needs of South Carolina's elderly citizens. Along the way I have had the good fortune to be appointed by Governor Riley to represent our State at the 1981 White House Conference on Aging, and later it was my pleasure to serve on the Governor's Resource Panel on the Elderly.

While serving on the Resource Panel I was appointed to the Long Term Care Committee. That committee provided me with valuable insight into our State's view of Long Term Care. I was then able to take that insight and put it to work as a member of the Long Term Care Committee of the National Association of Area Agencies on Aging (N4A).

The product of over three years of work is what I am presenting to you for your consideration. This position statement supports in total the concept our State has adopted to provide increased quality of care for the frail elderly of our communities. However, there are valid points within the statement which could offer alternate directions for us to take in our joint efforts to meet the needs of our aging population.

Page five of the position statement provides you with the definition of community based long term care as presented by the National Association of Area Agencies on Aging (N4A). As you can see, this definition is clearly different from the Long Term Care Model you are perhaps most familiar with today. The element included in the N4A definition which is most notably missing in the South Carolina Long Term Care Project is preventive care. Interestingly enough, the Aging Network has for ten years operated under this definition for something we have referred to as the "Continuum of Care."

The position statement next points out the current problems associated with service integration. A list of these problems can be found on page six of the statement, so I will not read each one. Instead, I will point out a few and give you N4A's recommendations.

First, fragmentation of services and duplication of administrative responsibilities are seen as major stumbling blocks to an effective care system. N4A recommends that strong consideration be given to strengthening the existing network of State Offices on Aging, Area Agencies on Aging, and county service providing agencies. The Association believes that the talent and overall knowledge currently exists within the so-called "Network on Aging" to accomplish a true continuum of care for the elderly population. ATTACHMENT II provides you with models from four states utilizing the Network. Please review these models at a time when you can compare the direction of those programs with the directions being taken by South Carolina.

Second, N4A points out that case management is an integral part of any long term care system. This point is in strong agreement with the direction we are going in South Carolina. I point this out merely to take the opportunity to say that the Area Agencies on Aging in South Carolina agree fully with N4A's viewpoint that Area Agencies on Aging must be involved in assuring effective case management systems are put in place.

Finally, N4A's long term care statement, while referring primarily to national legislative issues and funding sources, supports all legislative action which would enable preventive as well as "after" care of the aging population. The Community Service Legislation (H-2364) proposed for the State of South Carolina should provide a much needed resource for development of services to the aging population of our state.

In conclusion, N4A is supportive of all efforts to build a strong support system for the elderly of our nation. It is the position of N4A that the foundation for that strong system currently exists within the Network on Aging. State and Area Agencies on Aging have the structure and talent to facilitate optimal results for long term care; however, unless fully understood and used, that structure will not serve its mandated purpose.

Senator Rubin, so that you and the committee will understand Area Agencies on Aging better, I have also attached a summary sheet explaining our purpose and origin (ATTACHMENT III). Thank you and each committee member for your attention, and I look forward to working for you in the coming year.

GMD/ha
9/23/83

APPENDIX

First Baptist Church

Henry L. Chennault, Pastor
120 CHESTERFIELD STREET, NORTH
AIKEN, SOUTH CAROLINA 29801

September 19, 1983

Jack F. Hasty
Minister of Education

Senator Hyman Rubin, chairman
Joint Legislative Study Committee on Aging
Box 142
305 Gressette Building
Columbia, South Carolina 29202

Dear Senator Rubin,

The July-August issue of Vintage, a publication of the S.C. Commission on Aging, state that your committee would have a public hearing on September 23 on the problems and concerns of older South Carolinians. I will not be able to attend this hearing, but I do want to share some concerns.

The same issue of Vintage also carried an article which stated that "The Department of Health and Human Services(HHS) recently announced a policy which could force adults to pay some Medicaid costs involved in caring for indigent relatives in hospitals and nursing homes. A state-by-state option on the policy is in effect. "Relatives" is not defined."

I am opposed to HHS announced policy that would force adults to pay for medicaid "relatives" in hospitals or nursing homes.

This past week I have been ministering to an elderly couple(both are in their early nineties and both have hardening of the arteries) who need daily nursing care that they are not getting. They live in their own home. Their only income is his monthly Social Security check. The wife is ill and their family doctor has had her confined to the bed for the past sixteen days.

The husband has a widowed sister who lives in her home here in Aiken and she is in her upper eighties. He has another sister in the Greenville area who is a semi-invalid. The wife has a nephew. The nephew and his wife have moved into the house to try to help. But the nephew has had a stroke and is paralyzed in his left(?) leg and is unable to work, and his wife has not been able to secure a job in over a year.

If this elderly couple were admitted as medicaid residents to a nursing home there is no way their relatives could help pay the bill. No doubt there are hundreds of situations like this. I believe that the complete cost of caring for medicaid residents of hospitals and nursing homes should be borne by the government.

Thank you for this opportunity to express my concerns for the elderly.

Sincerely yours,

Jack Hasty

Jack Hasty
Minister of Education

cc: [illegible] B. ✓
[illegible] S.

Post Office Box 235, Aiken, South Carolina 29801 • Phone: 648-5447

Phyllis G. Pellarin, ACSW
Executive Director, Aiken Area Council on Aging, Inc.
Testimony to the Study Committee on Aging
Columbia, South Carolina
September 23, 1983

Senator Rubin and members of the Study Committee on Aging:

It seems my appearance before this committee and the testimony I plan to offer is becoming an annual event. With your support, last year some progress was made toward achieving our objective. However, that advance did not result in reaching our goal, and therefore another effort is required. I refer to State legislation to provide tax relief to volunteers who drive their own cars at their own expense in order to provide services to clients of nonprofit human service delivery agencies.

I can only reiterate what you have often heard before. The use of volunteers is essential to the function - even the existence - of many such agencies. Volunteers have been utilized to an even greater extent in recent years as agencies attempt to fill the service gaps created by decreased funding and budget cutbacks.

The Aiken Area Council on Aging continues to rely heavily on Volunteerism to supplement its funded services.

A large majority of our volunteers are utilized to deliver daily meals to homebound elderly persons. This requires the use of their own automobiles. During 1982, 460 volunteers contributed 8,688 hours of unpaid time, 6,012 of which were given by persons 60 years of age or older. Volunteers drove 36,164 miles for which they received no mileage reimbursement in order to deliver services to older South Carolinians. The value of their contribution in hours

served and miles driven is equal to $37,424.00, an amount of money not available to us from any source.

The high cost of vehicle operation prevents some senior citizens on fixed incomes from becoming volunteers, and, in addition, has forced others to give up this volunteer effort as prohibitively costly.

It is because the Aiken Area Council on Aging recognizes the vital contribution of volunteers to the success of our programs that we have advocated strongly on their behalf for legislation that provides the same level of tax relief that persons engaged in business requiring the use of their cars are allowed to claim. We feel that there is no valid reason for maintaining the inequity that permits business persons double the allowable rate for volunteers.

Gentlemen, once again, and for as often as it takes, I should like to respectfully request that the Joint Legislative Study Committee on Aging again support legislation to provide volunteers an increased measure of tax relief. This would indeed indicate a state-felt gratitude to volunteers who so unselfishly save us both time and money.

On behalf of all our volunteers, thank you.

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AMERICAN ASSOCIATION OF RETIRED PERSONS

25 YEARS OF SERVICE

October 4, 1983

Senator Hyman Rubin, Chairman
Senate Committee on Aging
P. O. Box 142
Columbia, SC 29202

Dear Mr. Chairman:

The American Association of Retired Persons with more than 15 million members nationwide and 119,000 members in South Carolina is concerned about the rapidly rising costs of health care especially for older Americans.

One means by which persons over age 65 can exercise individual control over health care costs is to seek out physicians who will accept assignment of benefits under Medicare. In this context, AARP is organizing a health advocacy program in the State of South Carolina. With the assistance of Ms. Keller Bumgardner of the Senate Committee on Aging, and other concerned citizens, I will be working with other AARP volunteers to organize survey teams in five-to-ten communities in South Carolina with the purpose of identifying physicians who do, and will, accept assignment. This information will then be widely disseminated to enable older consumers to make informed choices about physician services.

I appreciate the continuing assistance of Ms. Bumgardner on this project and the support of the Study Committee on Aging. I respectfully request that the enclosed remarks be included in the minutes of the hearing before the Committee on September 23, 1983.

Sincerely,

(Mrs.) Lola Mae Infinger
Volunteer Health Advocacy Coordinator
for South Carolina

Enclosure

Mr. Chairman and Members of the Study Committee on Aging:

My name is Lola Mae Infinger and I am a member of the American Association of Retired Persons, a national organization of more than 15 million members nationally and 119,111 members in the state of South Carolina. I am the Health Advocacy Services Coordinator for the state of South Carolina.

I respectfully request that these remarks pertaining to Medicare assignment of benefits to physicians be entered into the record of the minutes before the Study Committee on Aging, September 23, 1983.

There is a crisis in health care, and the entire system of health care is involved. We all are increasingly aware that the cost of health care is escalating at a considerably higher rate than other consumer items in these inflationary times. The years between 1968 and 1979 saw health care costs increase 20 percent faster than the overall cost of living.

One of the primary factors responsible for this is the cost of physicians services which has had a disastrous effect on elderly people suffering from tight budgets and reduced incomes, and has prevented many of them from seeking needed health care. Consider the impact on the elderly population--those 65 and older--who are becoming more severely burdened each day with health expenditures not covered by Medicare. Total per capita out-of-pocket costs for the elderly have increased by 75 percent over the past five years. Hospital care represents 14 percent of out-of-pocket costs; physician services account for almost half (42%) of out-of-pocket costs. Not much can be done by the consumer to reduce the costs of hospital care other than making a decision about elective surgery and getting a second opinion.

It is the cost of physician services where the individual has a choice--an opportunity to control out-of-pocket costs. Obviously, assignment of Medicare benefits to the physician becomes especially important. But it is often difficult to locate physicians in the community who will accept Medicare assignment.

<u>What is Medicare assignment?</u>

If a doctor accepts assignment, it means that Medicare will pay, directly to the doctor, 80 percent of the allowable charge for that service. The allowable charge is

determined by the Medicare carrier (Blue Cross/Blue Shield, for example) in that region. The patient is responsible for the remaining 20 percent of the allowed charge plus any part of the deductible which the patient has not met.

Here is an example: Let's say you visit a doctor in his office and he accepts assignment of benefits. He sends the claim to Medicare showing his charge as--say--$27. But Medicare decides that $18 is the allowable charge for the service in your area. Presuming you've already met your deductible, Medicare pays the doctor 80 percent of the $18 allowed charge, for a payment of $14.40.

The doctor can't make you pay more than the other 20 percent of the allowed charge because he accepted Medicare assignment. In this example, you are responsible for only $3.60--the difference between Medicare's $14.40 payment and Medicare's $18 allowed charge. The doctor cannot make you pay the difference between Medicare's $18 allowed charge and his actual charge of $27.

Here's another example: You have an operation and the doctor accepts assignment of benefits. His bill for the operation is $2,000. Medicare allows $1,500 and pays the doctor 80 percent of $1,500, for a Medicare payment of $1,200. Again presuming you've met your deductible, your total liability for the bill is the $300 difference between Medicare's $1,200 (80%) payment and Medicare's $1,500 allowed charge. The doctor cannot make you pay the remaining $500.

In this example, if you hadn't met any of your Part B deductible, Medicare would pay 80 percent of $1,500, less $75 (the deductible) for a payment of $1,125. Your total payment then would be the $375 difference between Medicare's payment and Medicare's $1,500 allowed charge. The advantage of using a doctor who accepts assignment is obvious: out-of-pocket costs are guaranteed never to exceed 20 percent of the charge allowed by Medicare plus the share of the deductible that has not been met.

Should the doctor not accept Medicare assignment, the doctor bills the patient for the total charge. Medicare then pays directly to the patient, its share of the bill--80 percent of the allowable charge. The doctor may handle the claim forms for the patient but, in many instances, the patient must do the paperwork. In either case, it is the patient who must wait to be reimbursed for out-of-pocket costs. A study of Part B claims for 1981 shows that,

nationally, only about half (52%) of physicians involved accepted Medicare assignment, representing a drop from 60.5 percent in 1969. In South Carolina, the percentage is only slightly higher--55.4 percent. This situation is "depleting the meager savings of millions of senior citizens." These figures are somewhat misleading, however. If a doctor accepts assignment once, he goes on record as accepting assignment and, yet, he may accept it only one time. A more accurate estimate of physicians who accept assignment on an on-going basis is closer to 30 percent.

How can doctors who accept assignment be located?

It is often difficult to determine which physicians in a community accept Medicare assignment. AARP, through its office of Health Advocacy Services, has developed and recently published a booklet entitled, Cost Containment Through Community Action: The Physician Assignment Survey. It is a "how-to" guide for determining which doctors in a community accept Medicare assignment and how often they do so. Results of the survey are compiled and disseminated in the community so that consumers can use the information in selecting a physician. It helps the consumer to avoid charges in excess of the Medicare allowable costs.

In addition, an assignment survey sensitizes the community to the problem of high medical costs and could perhaps encourage more physicians to accept Medicare allowable costs as full payment.

The results of surveys which have been conducted in several communities have been rewarding. For example, a survey was made in the Martha's Vineyard/Cape Cod area of Massachusetts. The results were compiled and published by Blue Shield of Massachusetts, Inc., and copies were made available to anyone requesting them. Consumers' awareness has been heightened as to their role in containing health costs. Health care providers have been alerted that consumers are concerned and are doing something about health care costs. But, most importantly, assignment information is made available for the consumer to use in making a choice.

Knowing the benefits to the health care consumer, AARP is undertaking a more extensive survey in South Carolina. I have been appointed as the Volunteer Health Advocacy Services Coordinator for South Carolina to conduct assignment surveys in five-to-ten areas of our state. The survey committee will work with local aging agencies, medical societies, civic groups and other volunteer and citizen organizations. The

results will be disseminated in each community where a survey is made. All older health consumers in the survey areas of South Carolina will benefit as others have--awareness by consumers and health providers alike that consumers can play an active role in controlling health care costs--and making the information available to them. Many doctors assert they do take assignment. The surveys will let people know who they are.

I respectfully urge the members of the Study Committee on Aging to recommend that surveys be conducted in South Carolina of physicians who accept assignment for the benefit of older people in South Carolina.

Most respectfully,

Lola Mae Infinger
Volunteer Health Advocacy Services
Coordinator

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2 October 83

Senator Hyman Rubin
305 Gressette Building
Columbia, South Carolina 29202

Dear Senator Rubin,
As a concerned citizen of South Carolina I would like to offer some of my ideas on the needs of the Senior Citizens of Richland County and the State of South Carolina.
I see a need for more Centers located in more accessable areas of the city. The ones available to the Northeast section are ten miles away and transportation is not available over six miles.
I understand that money has been appropriated for a site at Shandon Methodist Church that was supposed to be opened 1 September. I hope this information is correct, and that it will soon open. —
We need more activities geared to the elderly taking into consideration their abilities and interests. The Senior Citizen Center in operation now offers Clogging, Ballroom dancing, Bridge and Chess. While these are wonderful activities for the Seniors that can participate , there are many that aren't physically able or mentally capable to Clog or play Bridge or Chess.
Ideally, Day Care Centers that are open Monday through Friday, serve meals and have meaningful activities such as: daily exercises, pool table, shuffleboard, arts and handcrafts, painting,(a small fee could be charged for materials) field trips to the Zoo, State Fair, Art exhibits, Ballgames and other places of interest. Classes can be given on Health Problems, Problems on Aging, Nutritional needs, Special Diets and food preparation. Movies on Wildlife, SC History, Current events and problems and topics on Art.
Accompanied on walks, picnics, and going out to lunch at different resturants, (Many give Senior Citizen discounts).
Swimming or Golfing would be enjoyed by some.
Most of these suggestions would be inexpensive and others could be met through payment on sliding scale. Transportation could be possibly solicited through Auto Agencies and be tax deductable as a contribution, (if this is permitted.) or paid on sliding scale as some other states do.
These suggestions would make life more enjoyable and interesting for our Senior Citizens and keep them from inactivity, loneliness and depression. They would feel that "We Care" about them.
Another idea I have is to open "Boarding Houses" for 4 or 5 to live in. These could have a "House Person" for assisting with meals, medications and other minor needs. This would be for the mobile and self sufficient person with only minor health problems. The individuals could pay according to their income. In providing these homes the elderly wouldn't feel they are a burden to their family. This arrangement would help overcome loneliness by being with persons of their own age and same problems.
I hope we can continue with the great programs we have and to expand the servicesin the future.
I am fast approaching that age and would like to enjoy my old age in many of the things I have suggested.

Thank You,
Ellen F. Rodgers R.N.
3505 old Hampshire Rd
Columbia, S.C. 29206

September 27, 1983

The Honorable
Hyman Rubin
305 Gressette Building
Columbia, South Carolina

Dear Senator Rubin:

I was sorry to have missed the public hearing last Friday; nevertheless, I wanted to communicate my ideas about inexpensive adult day care as an alternative to expensive long-term care and institutionalization.

Adult day care, as you know, is a fairly new concept to the United States, but one that has worked well in a number of states. The socialization that occurs in adult day care has been proven to be a positive stimulus to maintaining the independence of the elderly. It can prevent premature debilitation and institutionalization. Families feel better, too, about their aging relatives remaining in the community and support structure where they have resided and where they probably are most comfortable. The growing numbers of the elderly are a golden resource we should not neglect.

Adult day care can be based on a medical model, a social model, or a combination of both. The medical model provides therapeutic treatments such as physical, occupational, and speech therapies. The social model provides the support of group activities and recreationsl therapies. Social day care can be provided at a cost of $15.00 to $25.00 a day. Medical day care would be more, $35.00 to $45.00 a day, depending upon services needed or prescribed. Fortunately, the elderly can purchase only the treatments they need in a cay care setting, rather than pay for an entire package of medical care that is offered in a nursing home or other long-term care institution.

Unfortunately, reimbursement policies can be barriers to participation. Participation in adult day care can reduce costs by preventing premature institutionalization. Home health care visits are reimburseable, but do not provide the opportunity to be with other people which can prevent isolation. Moreover, the wealthy elderly can purchase any care; the poor elderly have access to the few governmental programs that are available. The middle class elderly have neither.

I request your support of the concept of adult day care for the elderly population. Your investigation of removing the barriers to participation, particularly financial barriers, would be appreciated. Thank you for the opportunity to participate in public policy making.

Sincerely,

Ann Chadwell Humphries

Ann Chadwell Humphries
2814 Webster Street
Columbia, South Carolina 29205
771-6026-home; 765-7275-work